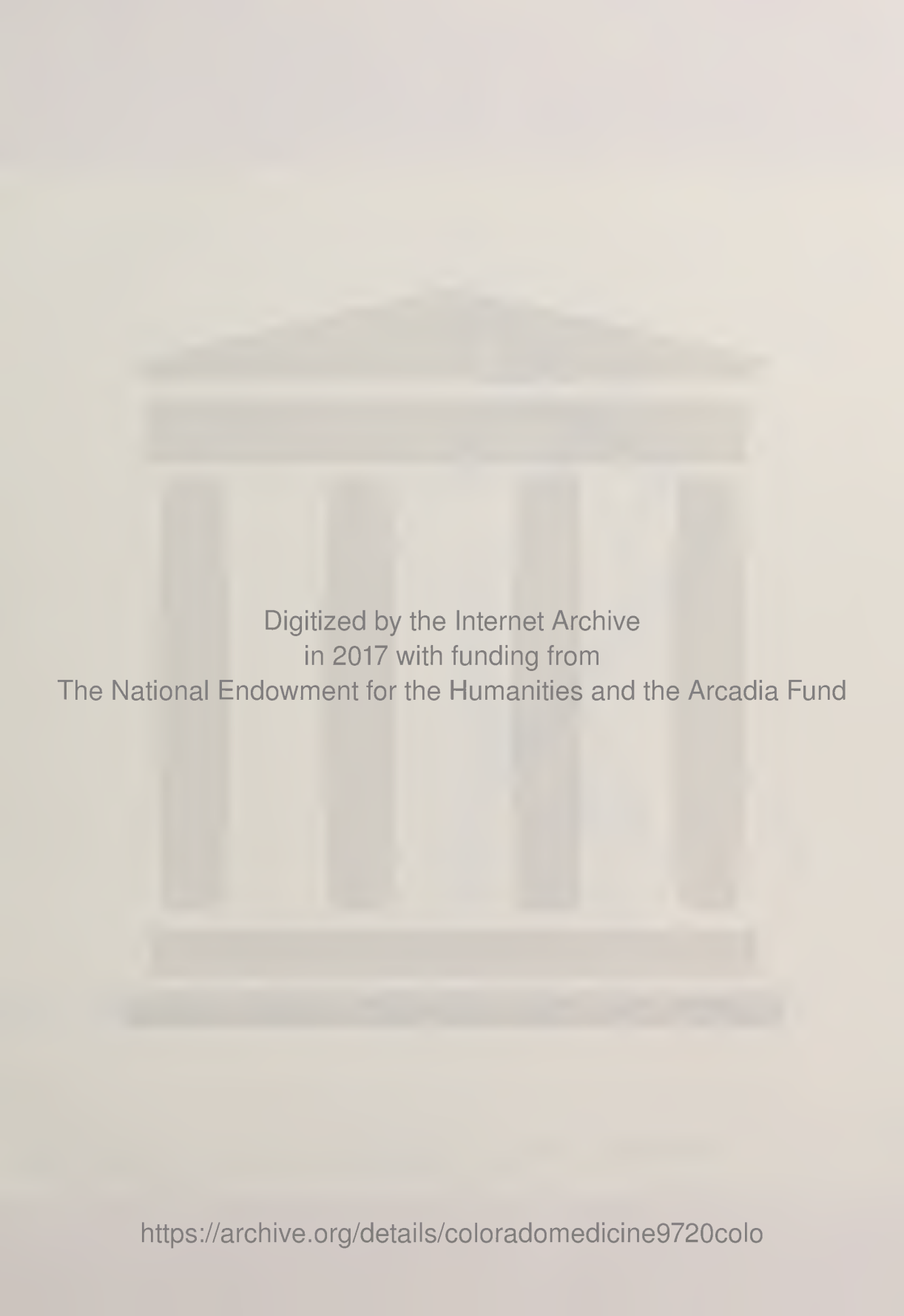

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Doc Rocky Says: "O O, are we ready?"

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COLORADO MEDICINE

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7800 E. Dorado Pl., Englewood, CO 80111. Telephone (303) 779-5455. Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

At the last Colorado Medical Society Board meeting, Dr. Robert Brockman, our resident representative on the board, asked me if there is a way the membership could be made aware of CMS's positions on legislative issues so that membership could have input regarding those positions. This is a great suggestion from an interested and involved young physician. We visited about the possibility of a survey, but surveying in a timely manner would be difficult and expensive, and physicians are surveyed excessively. I thought a better strategy might be to use this space prior to the legislative session, summarizing the issues being addressed at CMS in preparation for representing all of you. Then we can seek your input through the CMS Legislative Council and our legislative personnel.

We are aware of a number of important issues that are the subject of bills introduced this session and I will briefly discuss them here. More in-depth discussion of these and other issues can be found in an article in this journal by Chris Unrein, DO, your Legislative Council Chair.

- The Tobacco Settlement money continues to be up for grabs and it seems every interest group in the state and many of our state agencies would like to get their hands on at least part of it. One recent proposal we have seen would leave on 37% for use in health related programs with 63% going to education, infrastructure, et al. Your medical society's position is that 100% of these funds should be allocated to health care programs. Last year we convinced some members of the legislature this would be appropriate but they were not able to reconcile this issue with the state administration. A bill allocating these funds to tobacco cessation, increased health care for children and other important health related programs died. CMS will work vigorously to preserve all these funds possible for use in health care programs.
- A number of bills addressing the myriad ills of the managed care system are likely to be introduced. We will, of course, support those which fix problems for physicians and patients, though they are piecemeal. The CMS leadership is more interested in wholesale overhaul of our health care delivery system. I will discuss this further in next month's presidential article.
- We can expect some threat to tort reform and other legislation in the medical malpractice arena. We will work closely with Copic to add our support to their efforts in this arena.
- Prenatal care for undocumented women is a concept CMS certainly supports. A bill providing funding for such a program includes a provision placing regional administration of payment in the hands of a single managed care entity. It is important for CMS to ensure that physicians providing labor and delivery services for this population are reimbursed while encouraging prenatal care for as many women as possible. CMS continues to work on the details of this proposal.
- Two bills regarding scope of practice are expected, one regarding certified nurse midwives, the other optometrists. An arrangement between ACOG and the Certified Nurse Midwives Association will clarify current contradicting statutes and enable certified nurse midwives to work within collaborative agreements with physicians. This bill probably will be supported by the Council if it clearly outlines the responsibilities of both parties as they work together to provide care. A bill granting direct access to optometrists without prior approval or referral under managed care contracts will require careful scrutiny and discussion.
- Representative Brad Young from Lamar is introducing a bill that would grant a state income tax credit to physicians, nurse practitioners and physician

(continued on next page)

"Your direct communication . . . . is imperative so we can best represent you."

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assistants who practice in a genuinely rural area of Colorado. This concept has already been utilized to improve rural health care access successfully in two other states, Oregon and Georgia. It has increased the numbers of rural physicians, NP's and PA's in Oregon in the last four years by 500 + and largely alleviating rural shortages. This program required significant investment of public funds and was to have been sunset this last year but the Oregon legislature has chosen to continue it because of its success.

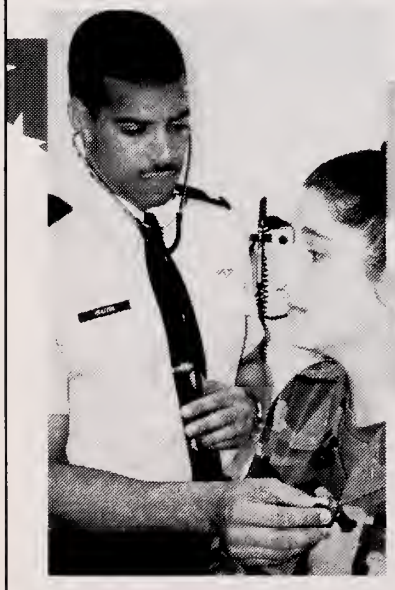
CMS proposed such a loan repayment program to the Colorado legislature several years ago and it was felt to be a good idea but funds were not made available to finance implementation. Two things have changed since then. First, the financial status of the state is more sound and the mood toward tax credits in the legislature and administration more open. Second, CMS has greatly improved its credibility in the legislature for itself and for such rural access programs by developing the CMS Foundation and its two programs, CROP and the Coalition for the Medically Underserved.

Most important of all is your (all members) input to, and support of, our legislative efforts. Your legislative council determines our official positions as we go to the State House and Congress to testify, lobby and develop legislation. Below you will find a roster of our legislative council. Your direct communication with them, our legislative staff, other staff or myself is imperative so we can best represent you in these legislative arenas.

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by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society



Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Caring for Children - Liability Concerns

by Patrick T. O'Rourke and Heather Weckbaugh

I. Introduction

Modern health care requires physicians to understand the legal landscape. Acquiring this understanding is challenging when the patient is an adult, but can raise even more complex questions when the patient is a minor. This article addresses some of the issues that physicians encounter when dealing with their minor patients.

II. Minors and Their Parents

The first question that naturally arises when dealing with legal issues pertaining to minors is "Who is a Minor?" Under Colorado law, every person under the age of twenty-one years is considered a "minor." *C.R.S. §2-4-401(6).*

Notwithstanding the definition of a "minor," every person is deemed to be "of full age" once he or she has attained the age of eighteen years. *C.R.S. § 13-22-101.* Every person eighteen years of age is considered competent to:

- Enter into any legal contractual obligation and to be legally bound thereby to the full extent as any other adult person;
- Manage his estate in the same manner as any other adult person;
- Sue and be sued in any action to the full extent as any other adult person; and, most importantly for medical providers,
- *Make decisions in regard to his or her own body.*

Therefore, health care providers are generally safe to assume that any person eighteen years of age or older can make his or her own decisions regarding medical care and treatment.

Below the age of eighteen years of age, only a person with "legal custody" possesses the person with the right to make medical decisions for a minor "Legal custody" means the right to the care, custody, and control of a child and the duty to provide food, clothing, shelter, *ordinary medical care*, education, and discipline for a child and, *in an emergency, to authorize surgery or other extraordinary care.* "Legal custody" may be taken from a parent only by court action. C.R.S. 19-1-103(73)(a).

Because "legal custody" most often resides with a minor's parents, a difficult situation is presented when the parents have divorced. Under Colorado law, the divorced parents of a child may be granted "joint custody," or one of the parents may be granted sole custody. "Joint custody" awards legal custody of the minor child to both parents and provides that all major decisions regarding the health, education, and general welfare of the child shall be made jointly. Under emergency circumstances, it is sufficient for either parent to sign legal releases or to take any other necessary measures. *C.R.S. §14-10-123.5(1).* Where there is joint custody and a dispute arises about the necessity of or the type of medical

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treatment provided to the minor child or children, either parent shall be allowed to obtain necessary medical treatment for the minor child or children without being in violation of the joint custody order or in contempt of court. *C.R.S. 14-10-123.5(8).*

"Sole custody" awards legal custody of the minor child to one parent and provides that parent with the authority to make all major decisions concerning the child's health, education, and general welfare. A health care provider may not, under normal circumstances, render medical care upon the consent of a noncustodial parent. In the event of a medical emergency, however, a noncustodial parent may consent to necessary medical treatment for the minor child. *C.R.S. 14-10-124(6)*

A parent of a minor, *by a properly executed power of attorney*, may delegate to another person, *for a period not exceeding nine months*, any of his or her powers regarding care, custody, and decision-making responsibility, including the power to consent to medical care and treatment. *C.R.S. 15-14-104.* Without a duly executed power of attorney, a health care provider based upon another person's consent could be held liable for rendering unauthorized medical care and treatment.

III. When Can A Minor Consent to Medical Care Without Parental Consent?

Although minors are generally considered incompetent to make their own medical decision, there are certain times when the General Assembly had determined that minors can be treated as adults. In these instances, where it is possible that minors would not seek medical care if they were required to obtain parental consent, the General Assembly has decided to encourage minors to seek medical care by allowing them to make their own medical decisions. These include:

A. Financial Independence

A minor of at least fourteen years of age who is living separate and apart from his or her parents or legal guardians and who is managing his or her own financial affairs (regardless of the source of income) may give consent for his or her own hospital, medical, dental, emergency, or surgical care. *C.R.S. §13-22-103(1).*

When a minor is capable of consenting to medical care because of financial independence, he or she may not later disaffirm the consent because of minority. The minor also acquires the same rights, powers, and obligations as if he or she had obtained majority, including the obligation to pay for any medical services rendered.

A health care provider who, *in good faith,* relies upon a financially independent minor's consent for medical treatment will not be held liable for failing to obtain parental consent. The minor's parents, however, will not be liable to pay the charges for the care, unless the parents have expressly agreed to be liable.

B. Marriage

Any minor who is legally married may give consent for his or her own hospital, medical, dental, emergency, or surgical care. *C.R.S. §13-22-103(1).*

When a minor is capable of consenting to medical care because of marriage, he or she may not later disaffirm the consent because of minority. The minor also acquires the same rights, powers, and obligations as if he or she had obtained majority, including the obligation to pay for any medical services rendered

A health care provider who, *in good faith,* relies upon a married minor's consent for medical treatment will not be held liable for failing to obtain parental consent. The minor's parents will not be liable to pay the charges for the care, unless the parents have expressly agreed to be liable.

C. Minors Who are Parents

Any parent, including a parent who is a minor, may request and consent to the furnishing of hospital, medical, dental, emergency health, and surgical care to his or her child. *C.R.S. §13-22-103(3).*

The consent of a minor parent shall not be subject to disaffirmance because of minority, and, when such consent is given, said minor parent has the same rights, powers, and obligations as if he or she were of legal age.

D. Birth Control

With the exception of abortion, physicians may provide birth control procedures, supplies, and information to any minor who requests and is in need of birth control procedures, supplies, or information. *C.R.S. §13-22-105.* Colorado law specifies that no abortion shall be performed on an unemancipated minor until at least 48 hours after written notice of the pending abortion has been delivered to the parents of the minor. If the minor does not wish to obtain parental consent, she may apply to a local district court for a determiantion that parental notification will not be in the best interest of the minor or that the minor is sufficiently mature to decide whether to have the abortion.

E. Venereal Disease

Any physician who has the consent of a minor patient may make a diagnostic examination for venereal disease and may prescribe for and treat such minor patient for venereal disease without the consent of or notification to the minor's parents or legal guardian. *C.R.S. §25-4-402(4).*

In any such case, the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment. The physician remains potentially liable for any negligent acts or omissions.

F. Addiction

Any physician who has the consent of a minor patient, may examine, prescribe for, and treat such minor patient for addiction to or use of drugs without the consent of or notification to the minor's parents or legal guardian. *C.R.S. §13-22-102,* In any such case, the physician or any person acting pursuant to the minor's direction shall incur no civil or criminal liability by reason of having made such examination or prescription or having rendered such treatment. The physician remains liable for any negligent acts or omissions.

G. Youthful Offenders

During the duration of a minor's incarceration in the youthful offender system, he or she no longer needs the consent of his or her parents or legal guardian to authorize hospital, medical, dental, emergency health, or emergency surgical care. *C.R.S. §16-11-311(4.5).*

No health care provider who, in good faith, relies on such a minor offender's consent shall be liable for civil damages for failure to secure the consent the offender's parents or legal guardian prior to rendering such care.

The parents or legal guardian of a minor offender may be liable to pay the charges for the care provided the minor.

H. HIV Infection

Any qualified physician or health care facility may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment.

The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the physician or facility to *any person* other than the minor except for purposes of making the required report to the Department of Health or a report of suspected or known child abuse.

If the patient is *less than sixteen years of age*, the physician may, *but is not required to*, provide information concerning the patient's consultation, examination or treatment to the parents or guardian. *C.R.S. §24-4-1405(6).* If the patient is *sixteen years of age or over,* the physician may not disclose any information to the parents or guardian without the patient's consent.

In all cases involving HIV infection, the physician or other health care provider must counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment.

IV. Emergencies

Situations may arise where a physician needs to provide emergency medical care to a minor, but the physician has not been able to obtain consent from the minor's parents. In this situation, the General Assembly authorizes the physician to undertake a course of treatment designed to promote the minor's immediate physical or mental health. Before providing any such emergency care, however, the physician must determine that:

- No one competent to consent can be consulted; and
- A reasonable person, wishing to safeguard the welfare of the patient, would consent. *C.R.S. §18-1-703(1)(e)(I-II).*

Because the key to providing care in emergencies is that the physician must act reasonably, we recommend that physicians document the efforts they made to contact the minor's parents and the reasons why they believed that it was necessary to render emergency medical care without having obtained prior parental consent.

V. Conclusion

Legal issues involving minors and their medical care raise complicated and confusing questions. For example, a fourteen year old female with a child is considered competent to consent for her child's medical care, but not her own. In situations involving the care of minors, we recommend that physicians adequately document their concerns and consult with legal counsel if time permits.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

The 31st Annual Cardiovascular Conference at Snowmass
January 17 - 21, 2000
Snowmass, Colorado
Contact: Registration Secretary, Extramural Programs (800) 253-4636 ext 695

Women's Health 2000: Creating New Models for Comprehensive Care
January 20-22, 2000
The Radisson Hotel Sacramento
Sacramento, California
Contact: Lisa Tooker at (800) 487-4325 or *ltooker@cme-webcredits.org*

Clinical Diabetes & Endocrinology in 2000
January 30 - February 3, 2000
Snowmass Conference Center
Aspen, Colorado
Contact: Lei Anne Oborne, (800) 421-3756 or *mer@dnvr.uswest.net*

11th Annual Rural Health Policy Institute
February 7 -9, 2000
Washington Court Hotel
Washington, DC
Contact: NRHA's Government Affairs Office (202) 232-6200 or *www.NRHArural.org.*

Cardiovascular Conference at Snowbird
February 16 -19, 2000
Snowbird, Utah
Contact: Registration Secretary, Extramural Programs (800) 253-4636 ext 695

26th Annual Vail OB/GYN Conference
February 20 - 25, 2000
Vail, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

Ski & CME Midwinter Conference
February 27 - March 3, 2000
Keystone Lodge & Resort
Keystone, Colorado
Contact: Brooke Chynoweth, (303) 322-1956 or *info@Colorado DO.org*

The 7th Annual Echocardiographic Workshop on 2-D and Doppler Echocardiography at Vail
February 28 - March 2, 2000
Vail, Colorado
Contact: Registration Secretary, Extramural Programs (800) 253-4636 ext 695

CRASH 2000 - Colorado Review of Anesthesia
March 4-10, 2000
Marriott's Mountain Resort
Vail, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

Pulmonary & Critical Care Medicine Conference
March 15 -18, 2000
Big Sky Ski Resort
Big Sky, Montana
Contact: (406) 442-6556 or *alamty@aol.com*

Recapturing the Soul of Medicine
March 29 - April 2, 2000
Seabrook Island, *The Conference Resort*
South Carolina (near Charleston)
Contact: (800) 621-8335

Endourology 2000
March 31, 2000
University of Colorado Health Sciences Center
Denver, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

4th Annual Ophthalmology Symposium
March 31 - April 1, 2000
Denver, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

40th Annual Conference on Legal Medicine
March 31 - April 1, 2000
San Diego Hilton Beach & Tennis Resort
San Diego, California
Contact: ACLM (800) 433-9137 or *info@aclm.org*

5th International Conference on Pediatric Trauma
June 17-20, 2000
Vail-Beaver Creek, Colorado
Contact: (719) 365-5888 or *www.pedtraumaconf.org*

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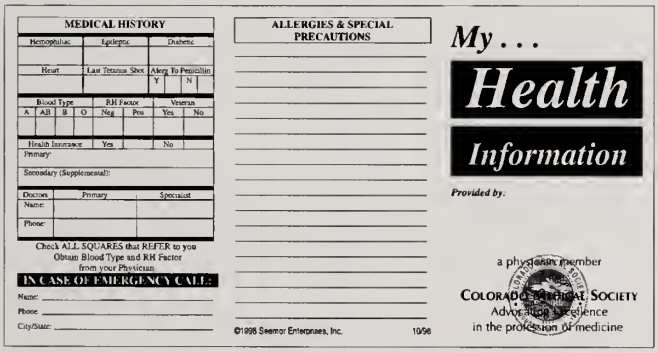
If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

Physicians Advocating for the patient

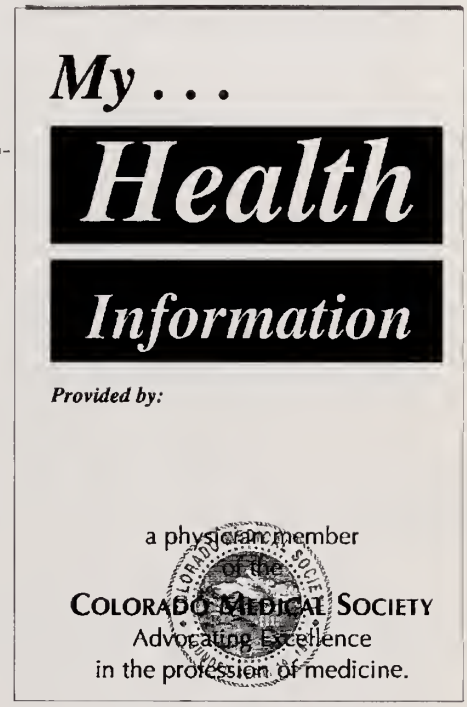
Every day we are reminded that patients of all ages do not follow their physician's directions very well. We hear of patients taking seriously conflicting substances, such as taking an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among the older citizens.

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of the medications they are prescribed, what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions.

CMS Member Services had come up with a handy device that can be supplied your patients for this very job, and at a low cost. The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as your medical needs and will hold up a long time.



1/2 of actual size



Actual size of folded card

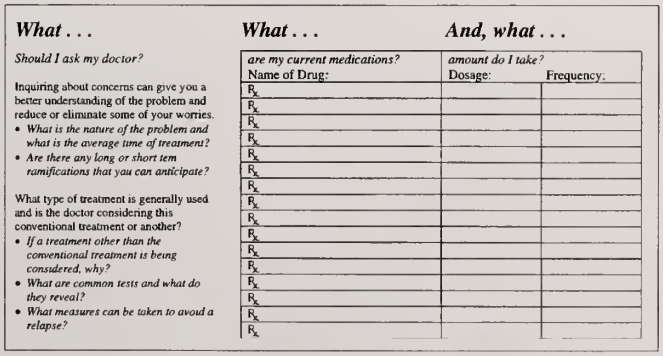
These health/medication records allow you to place a doctor identification on the front in a space 3/4" deep by 2" wide.

We at CMS feel that your patients will appreciate you for providing them with this, and will be a constant reminder of the quality of care and concern you have for their healthy well-being.

If you would like to try these cards, they can be ordered in lots of 100 @ $0 .40 ea = $40.00. This includes postage paid delivery. Sorry, but we cannot handle any orders less than 100 right now.

The cards are on hand and available now from CMS. They are an exclusive CMS member service. In time, they will be widely available, but for now, CMS is the only place you'll find them.

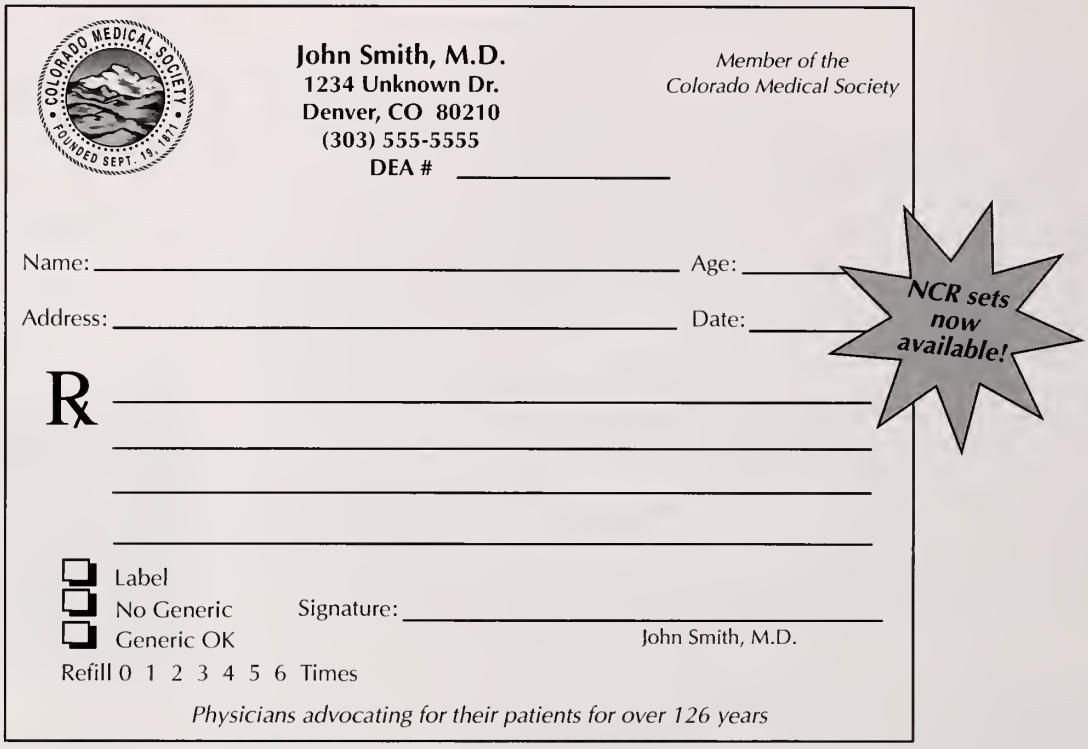
If you wish to order, send payment in advance to CMS, Member Services, P. O. Box 17550, Denver, CO 80217-0550. Delivery will be within the week.



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Plain paper and alter-proof NCR Rx pads are available. Plain pads consist of 100 pages of 20 lb. stock paper, printed with the personalized information you supplied above, and padded. NCR sets allow you to retain a copy of every Rx you write. Shipping and handling is included in the cost. **To order check below:**

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Order today and let your patients know that you are a proud member of the Colorado Medical Society.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Right now, there are about 5,500 member doctors in CMS. That's good news and that's bad news, all at the same time. Good news because there is strength in numbers; bad news because misery loves company.

Let's deal first with the bad news, of which there isn't much:

• Every day brings more news of inroads being made into the physician's practice, into the very science of medicine. There seems to be no way to turn the tide. . . except through numbers joined in a single voice. In November, I wrote of the repetition that occurs in the state legislature with more than one initiated referendum. I have no doubt but that this will happen in the 2000 session. With these repeat issues, plus the many other medical practice "invasions without qualifications," one voice representing the medical practice field is a must!

• Many physicians are presently suffering from the miseries put upon them by bad contracts with insurance companies and managed care firms; they're also suffering at the hands of their own fellow physicians who have interceded between the practicing physicians and the insurance companies. At the moment, there seems to be little that Colorado Medical Society can do for these physicians. We will keep trying with ever-increasing resolve.

Now, the good news:

• While the misery rises, the hope brightens that we'll see positive changes in this proud profession. Numbers of doctor spokespersons are increasing, strengthening medicine's voice.

• The patients are seeing the difference between "managed care" and "physician care," and they don't want any more "managed care".

• The "bottom line" of the managed care organizations and companies is beginning to wear thin: so many insurance aspects of these plans have faded away, been stripped or cut out completely, that the patient (insured) is no longer willing to put up with the plan(s). When the number of disgruntled health care consumers grows to the point that managed care can no longer manage care (because it is not profitable), there will be a sea change in the health care and medical practice fields. Can we hold out until then?

• Health Maintenance Organizations (HMOs) are, in great numbers, finding out that they can't handle Medicare members, and many are "opting out of Medicare."

The government put the load on the doctor's back a few years ago, and now the load is partially on the back of the HMOs, and they can't handle it either.

• Some physicians have seen their costs of practice leveling out to a more manageable percentage of gross. CMS does offer services that help. Doctors are seeing proper coding, office efficiencies and, yes, even handling of insurance claims and paper work, improved with help of CMS services. I urge you to take advantage of the expertise we have among the CMS staff, particularly in coding. The "hassle factor" project has helped us at the legislature to reduce some of the frustration

• CMS enjoyed a "positive" legislative year in 1999. I mean, we saw the defeat of more medically bad bills, the passage of more medically good bills, and handled the whole legislative session in a very smooth manner.

"Now, the good news:"

We saw the passage of an era with the retirement of Lorraine Koehn at the end of last year's session, but we also saw the smooth transition to a new Government Affairs Director, Suzanne Hamilton, and a new lobbyist, Kirsten (Spilde) Swart. We continue to change to meet the legislative needs.

• CMS efforts in the 2000 session will be just as effective, I am sure, as last year. There are legislative ideas afoot right now which, if passed, will see medical practice in a more positive position to be the greatest aid to the patients.

• Because of the increased number of members, CMS is able to realistically look at broadening our influence, hopefully in the areas of helping physicians protect their practice and their livelihood.

Only time will tell, but the current of optimism is running strongly (at least today).

Education for Physicians on End-of-Life Care

An Intensive Course for Practicing Physicians

Friday & Saturday, February 11-12, 2000

Executive Tower Hotel, 1405 Curtis, Denver

Sponsored by
Colorado Medical Society
Copic Insurance Company
The Program in Health Care Ethics, Humanities & Law, UCHSC

Program Directors

John D Armstrong II MD MA	Jean S Kutner MD MSPH
Phillip L Engen MD	Bruce C Richards MD

Palliative care is interdisciplinary care that focuses on the relief of suffering and improving quality of life. Physician participants who complete this intensive course in palliative care will be prepared to provide state-of-the art care for patients with chronic and life-threatening illness and be prepared to share this information with other colleagues in the health care professions.

Agenda

Friday, February 11, 2000

7:45 am	Continental Breakfast
8:30 am	**Welcome and Introduction to the EPEC Conference:** *Jack Berry MD*
8:40 am	Pre-Test
9:00 am	**Plenary One - Gaps in End-of-Life Care:** *Bruce C Richards MD*
9:45 am	Transition Break
10:00 am	**Module One - Advance Care Planning & Goals of Care:** *John A Armstrong MD MA; Phillip L Engen MD; Jean S Kutner MD MSPH; Bruce C Richards MD*
11:00 am	Break
11:15 am	**Module Two - Communicating Bad News:** *John A Armstrong MD MA; Phillip L Engen MD; David Nowles MD MPH; Bruce C Richards MD*
12:15 pm	Lunch
1:30 pm	**Module Three - Pain Managment I: Assessment: The Cornerstone to Optimal Pain Management:** *Phillip L Engen MD; Regina Fink RN PhD; David Nowles MD MPH; Jean S Kutner MD MSPH*
2:30 pm	Break
2:45 pm	**Module Four - Pain Management II: Building Blocks to Optimal Pain Management:** *Phillip L Engen MD; Regina Fink RN PhD; David Nowles MD MPH; Jean S Kutner MD MSPH*
3:45 pm	Break
4:00 pm	**Plenary Two - Advance Care Planning 101: Important Legal Doctrines:** *Ben A Rich JD, PhD*
4:45 pm	Questions
5:00 pm	Adjourn

Saturday, February 12, 2000

7:45 am	Continental Breakfast
8:30 am	**Plenary Three - Common Legal Issues That Arise in End-of-Life Care:** *Ben A Rich JD PhD*
9:30 am	Transition Break

Saturday, February 12, 2000 - continued

9:45 am	**Module Five - Whole Patient Assessment & Common Physician Symptoms:** *Phillip L Engen MD; Regina Fink RN PhD; David Nowles MD MPH; Jean S Kutner MD MSPH*
10:45 am	Break
11:00 am	**Module Six - Anxiety, Delirium, Depression:** *Regina Fink RN PhD; David Nowles MD MPH; Jean S Kutner MD MSPH; Bruce C Richards MD*
12:00 pm	Lunch
1:15 pm	**Module Seven - Sudden Illness:** *John A Armstrong MD MA; Phillip L Engen MD; David Nowles MD MPH; Jean S Kutner MD MSPH*
2:15 pm	Break
2:30 pm	**Module Eight - Medical Futility, Withholding and Withdrawing Treatment:** *John A Armstrong MD MA; Phillip L Engen MD; Jean S Kutner MD MSPH; Bruce C Richards MD*
3:30 pm	Break
3:45 pm	**Plenary Four - Next Steps:** *John D Armstrong II MD MA*
4:30 pm	Post-Test & Course Evaluations
5:00 pm	Adjourn

Education for Physicians on End-of-Life Care

Registration Form

An Intensive Course for Practicing Physicians
Friday & Saturday, February 11-12, 2000
Executive Tower Hotel, 1405 Curtis, Denver

Palliative care is interdisciplinary care that focuses on the relief of suffering and improving quality of life. Physician participants who complete this intensive course in palliative care will be prepared to provide state-of-the art care for patients with chronic and life-threatening illness and be prepared to share this information with other colleagues in medicine and nursing.

Registration for this program will be limited to 150 physicians.
Please register early to confirm your participation.

Name (Please type or print) _____

Office Phone _____

❑ CMS member — Component Society _____
Registration fee: **$100**

❑ Non-CMS member — Affiliation _____
Registration fee: **$200**

Please mail your registration form along with your check to
CMS, P O Box 17550, Denver, CO 80217.

Hotel Reservation Form

The Executive Tower Hotel
1405 Curtis Street, Denver, CO 80202
Phone (303) 571-0300 or (800) 525-6651
Fax (303) 825-4301

Colorado Medical Society
Education for Physicians on End-of-Life Care
February 11-12, 2000
$89.00 single, $99.00 double, $10.00 for each additional person

Name: _____ Number of guests: _____

Address: _____

Daytime Phone: _____

Arrival Date: _____ Departure Date: _____

Check-in time - 4:00 p.m.; Check-out time - 12:00 noon

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Guarantee Status: To hold the room for arrival later than 4:00 p.m., please provide a credit card number below, or forward one night's deposit. The hotel cancellation policy is by 4:00 p.m. on the date of arrival to avoid any charges.

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Please fax form to Attn: Reservations at (303) 615-5110.

If you have any questions or need more information, please call the hotel at (800) 525-6651.

Dear Ms. Maloney:

I have read Dr. Berry's article and talked to Bill Pierson. My original request was seeking advice regarding the PacifiCare actions relating to payment in 2000. I had the feeling this contract was not available to the Medical Society when Dr. Berry wrote his article.

The transition in medical care from a profession to a business accelerated during the years when I was more active in the medical societies. I remember when the insurance company first offered the PPO concept and physicians flocked to the concept. They were convinced this would provide them more patients resulting in more income. They forgot that who pays the bills dictates the terms. Which is one reason we are in the dilemma we are in now. Dr. Berry summarizes the situation quite well. It (his article) also stimulates comments.

The medical societies have always served well in the field of medicine, ancillary office & personal help for the physician. It is now time for leadership in the medical community. We must expand our horizons. Can the Medical Society assume that role? The present system has groups of physicians, some of which are "pods". This isolates, divides and conquers physicians. Each has attempted to deal with the insurance companies ("They"). "They" have more money, power and clout than a small group of physicians competing with each other for a better fee schedule. "They" do not have an interest in the patient but in the business. We must deal with our emotions related to the care of the patient. Emotions and business make poor partners.

Next, I would like to address the measures Dr. Berry wrote:

1. *(Continue to work for major and innovative health care system reforms).* The healthcare system reform currently and slowly, since Roosevelt's New Deal, and now rapidly, has become socialized. It has chased the physicians into controlled practices, including but not limited to, hospital employment, insurance company employment (like Exempla), pods with limited access practices, IPAs, etc. We even have Guidelines for numerous illnesses and injuries. Do you see the federal government standing in the wings ready to take over? Dr. Berry's well meaning statement is too broad and non-committal. It needs detail and substance. This is survival time.

2. *(Pressure third party payers to adopt systems that increase access to care.)* Forget it. That's like trying to change your spouse. "They" do not care about access to care. Money, money, money is their only concern. They want physicians to carry the burden of financing medical care while they lower their fees for patients and lower payments to physicians to cover that new lower fee or lower increase in fees.

3. *(Help third party payers understand that insurance premiums cannot be so low that physicians can't make a living).* Why should physician fees be related to insurance premiums? Insurance premiums should be related to insurance companies' cost of operation. Physician fees should rise with inflation, at least, and cost of their operation. The current method of determining physician fees must return to the physician. Physicians must not share insurance company cost of operations. It is impossible to get inside "their" brain. They are bold and demanding. We must resist their demands and make our own demands. We must stop being condescending and apologetic. We must take action and take control.

4. *(Meet with insurance commissioner to discuss issue of physician organization risk).* Meeting with the insurance commissioner may get us a little help. Unfortunately the commissioner doesn't have enough power and too narrow responsibilities.

5. *(Continue efforts toward working relationships with physician organizations).* Not enough. It is too late for that strategy to work. It has not and is not working. Physician organizations and individual physicians must not only work with one another, they must work as one. If we speak as one voice and are strong enough to maintain our stance we can win. Who will be that voice? Will the Medical Society be that voice? Will the Medical Society help us find that voice? Will a strong voice or voices appear? It must be a physician or his/her alter ego to lead. We have tried to get intermediaries with little to no success. There are too many middle men. Then we must be strong enough to fight the current trend. We must be willing to forget our emotions in the field of business. This is our one major problem - get thousands of individual thinking physicians to agree. If this does not occur we will be slaves to the system forever.

6. *(Develop any and all contract analysis tools we can, making them available to member physicians).* Develop a contract from the physicians to present to insurance companies or modify "Their" contract to fit our needs.

Sincerely,
Clarence Kluck, M.D
Denver



John L. Lightburn, MD
Historian
Colorado Medical Society

From Boom to Bust!

". . . a fabulous era."

The "twenties" were a fabulous era. As Charles Dickens said about another time, "These were the best of times and the worst of times." Good conservative presidents (Harding, Coolidge and Hoover) were in the White House and we were rich and prosperous; these must have been the best of times. But the prosperity was not shared by all. Farmers and laborers were poorly paid.

And there were many who were troubled by the loss of traditional Anglo-Saxon, Christian values. Moralists like William Joseph Simmons, Imperial Wizard of the Knights of the Ku Klux Klan, was organizing campaigns against the new morality, and also against the Jews, Catholics, Negroes and foreigners. He was organizing Klans throughout the country and came to Denver in 1921 to recruit a nucleus for Klans in Denver and Colorado. This nucleus rapidly grew into a rich and powerful Klan organization with 17,000 members in Denver and 50,000 in the state. With numbers like that, they became politically powerful and elected Klan members to the offices of United States senator, Colorado governor and Denver mayor. With bombings, cross burnings and parades, they terrorized Catholics, Jews and Negroes.

Leading the Klan was Dr. John Galen Locke, a Denver physician, who was the Grand Dragon of the Denver Klan. Not content with being a power in the state, he made plans for the Klan take over the state medical society. He would restore good Christian values to the medical profession.



John Galen Locke

By 1924 there was a strong Klan presence in the society, but there was also a strong anti-Klan faction.

Concerned by the potential destructive division that might develop, reasonable physicians led by Dr. George A. Boyd and George Curfman effectively blocked Dr. Locke's plans. The extremism of the Klan offended many and the fortunes of the Klan declined as rapidly as they had grown. Legal and tax problems beset Dr. Locke and his power faded away. It is unfortunate that John Locke had not followed the example of another Dr. John Locke, an English physician, who became famous in 1683 for his philosophical essays on human thought and freedom.

At the same time the flamboyant John Galen Locke was disturbing the peace in Denver, a gentle and compassionate physician was making his mark in the small town of Salida. He was our 56th CMS President (1926-27), George H, Curfman. This gentle, soft spoken physician was a contrast to his predecessor, the boisterous and outspoken Dr. Boyd. Underlying Dr. Curfman's quiet demeanor was a tenacious and brilliant mind. He was graduated cum laude from Northwestern University School of Medicine in Chicago in 1905, and completed his internship at Cook County Hospital where he was recognized as an outstanding clinician. He was admired by both faculty and students.



George H, Curfman

So why did a man with such promise end up in a small railroad town in the middle of the Rocky Mountains? One of his mentors had been Dr. J. F. Roe. When Dr. Roe left Chicago to become Chief Surgeon of the ***Denver and Rio Grande Western Railroad*** and the Senior Surgeon at the railroad's hospital in Salida, he remembered that brilliant young student and in 1906 invited Dr. Curfman to join him in Salida. George Curfman started out as an assistant surgeon, and when Dr. Roe moved to Denver, young Dr.

Curfman became senior surgeon and director of the hospital. Curfman's knowledge and skill in the medical sciences and his skill as a surgeon soon established that little hospital as the medical and surgical center of Central Colorado. Railroad employees were proud of their hospital and often referred to it as "the Mayo Clinic of the Rocky Mountains".

Curfman eagerly shared his knowledge with his colleagues and



D & RG Western Railroad Hospital
Salida, Colorado.

was a frequent speaker at local medical society meetings. Some of his papers appeared in ***Colorado Medicine*** and are a good read even today. One article, 'The role of Catharsis in Operative Conditions", read before the San Luis Valley Medical Society, reflected his concern about the overuse of cathartics by his colleagues. After presenting a scholarly review of the physiology of the gastro-intestinal tract, he concluded "that all forms of catharsis, especially in acute abdominal conditions, are harmful." A somewhat radical position back then.

In another article entitled "Botulism", he described the treatment of four patients who had been referred to him by the mining camp physician near St. Elmo. Seven persons had become seriously ill after eating a meal of beef steak, canned beans, canned spinach, orange fritters and mince pie. Of the seven who had become ill, five died. Of the four referred to Dr. Curfman, two survived.

He was best known, however, for his dealing with the Influenza epidemic of 1918. He persuaded Laura Evans, famous "madam", to close Salida's red light district for the duration of the epidemic. To keep the "girls" busy, he enlisted these "ladies of the night" to report for physical examinations and clean up to become volunteer nurse aids at the hotel he had converted into an emergency hospital. He had read a report from Toronto on the successful use of intravenous Carrell-Dakin solution in the treatment of an anthrax septicemia. He was the first to try this therapy on seriously ill influenza patients and he found it valuable.

When he was elected President of CMS in 1926, Dr. Curfman's goal was to encourage and foster a greater degree of cooperation and collaboration in the medical profession. In his presidential address read at the annual meeting in Colorado Springs on September 22, 1926, he first agreed that physicians must never be hampered in their "individualism". The physician should be free to exercise his best judgment in "his valiant struggle against disease." But then he presented vital statistics that showed an increase in the mortality rates in surgical conditions such as appendicitis, gastro-intestinal ulcer, diseases of the gall bladder and thyroid. He concluded that these statistics demonstrated need for cooperation and collaboration. To accomplish this, local and state medical societies needed rejuvenation. It was important to cooperate with the American College of Surgeons' new program to standardize hospitals and surgical procedures. In addition, cooperation was needed in the field of Public Health and disease prevention. There is so much that the individual physician cannot do alone. That was a difficult message for some solo physicians who cherished their freedom and independence. For some of us, it still is a difficult message.

William A. Sedwick was our 57th President, 1927-28. He had received his M.D. from the University of Maryland in 1893. Soon after his internship, he received the bad news that he had pulmonary tuberculosis. His response was to come west and settle in Rock Springs, Wyoming. Cures came slowly in those days, but eventually he became well enough to start a general practice, first in Rock Springs and then in Durango, Colorado. In 1904, he returned to his native Maryland to study ophthalmology in Baltimore and then in Philadelphia. Deciding that Colorado was not so bad, he returned to Denver where he established a successful practice in ophthalmology. He became active in the medical society and was known as dependable, prudent and conservative. In 1914, it became apparent that the CMS annual dues should be increased from $3.00 to $5.00, a 66% increase! The House of Delegates opposed this extravagance. It was clear the raise was inevitable, so they elected Dr. Sedwick to the office of Treasurer. They elected him for three additional three year terms. That was real dedication! The society had no staff; he collected the dues, paid the bills and kept the books for twelve long years. After this service to the society, the tight-fisted Dr. Sedwick became President-elect and the 57th President in 1927. The United States treasury was in good hands with Calvin Coolidge and the society's treasury was safe with William Sedwick.



William Sedwick

Sam Childs, our 58th President,

(Continued)

almost chose another career. Born in Hartford , Conn., in 1861 to a family of a prominent physician, his first love was baseball. At Yale, he was first baseman in a championship team. After graduation, he played professional ball with Hartford where he became a lifelong friend of teammate Cornelius McGillicuddy, who later became the venerable Connie Mack, manager of the Philadelphia Athletics. His baseball career ended when his father's "encouragement" persuaded him to enroll in medical school at the University of the City of New York. He might have been better off in baseball because in 1895, after several years as a successful surgeon in Hartford, he became ill with pulmonary tuberculosis. He "chased the cure" first in the Everglades of Florida and then, for three years, in El Paso, Texas. In 1898, he moved to Denver where he set up a surgical practice and began teaching anatomy at the Denver and Gross Medical College. When Dr. Childs read about Roentgen's discovery of the x-ray, he was determined to specialize in that new field. He became well known in his new specialty and in 1902, he was the first to make a radiologic diagnosis of a renal stone. The diagnosis was subsequently confirmed by surgery by Dr. W. A. Jayne. He advanced rapidly in his field, teaching at the University and writing numerous papers published in local and national medical journals.



Sam Childs

When he became President of CMS, Dr. Childs helped create a full time staff and employed the Society's first full-time Executive Secretary. Unlike his frugal predecessor, Dr. Sedwick, he had a mission for the Society: the restoration of esteem and prestige to the medical profession. In his presidential address, he asked why there were 30,450 cases of small pox in the past year when this dread disease was completely preventable? He then said, "The treatment of women at childbirth and the medical care they receive may be considered a criterion of civilization. America's backwardness in eliminating death at childbirth is a cause for shame, for among the twenty countries which record death rates at childbirth, the United States ranks nineteenth." Only Chile had a worse record.

He wondered if our country's failure to use the medical profession's scientific knowledge and skill was due largely to the public's distrust of physicians. Why were physicians held in such low esteem. "Never before . . . have the leading magazines and newspapers contained so many critical articles while innumerable attacks upon the integrity of the profession have been made in our state legislatures." He thought there might be several causes for the profession's loss of public esteem and prestige. First, he said that the physician's knowledge and skill had been cheapened by the proliferation of free clinics and hospitals. He admitted that such institutions were necessary, but there is an abuse of this charity by persons who are able to pay. Also contributing to loss of esteem were the anti-vaccination crusaders, the Christian Scientists, anti-vivisectionists and various other sects. He called for a vigorous program of public education to counteract their influence.

Dr. Childs then criticized the practicing physician for his lack of knowledge of physical therapy. He also criticized "fee splitting" and physicians accepting payment to provide conflicting testimony as expert medical witnesses. He pointed to the decline in rural physicians. In addition, he said, "something is wrong with medical economics, for with all but the very rich the cost of illness is a major burden." He reassured his listeners that a five year program of research was being established at Stanford University to answer the question of how a family of modest means can obtain adequate medical care. (We are still working on that question 70 years later).

He ended his presidential address with these words: "If he would regain his lost prestige, one change seems imperative, and that is a change which must come in his personality, for he must become more humane and less commercial, he must acquire a knowledge of human nature with a sympathetic understanding of human motives. . . and most vital of all, a human sympathy and compassion."

We will never know if his diagnosis or his prescription were correct, because thirteen months later the stock market crashed and the United States sank into the "Great Depression", the worst economic calamity ever experienced by this nation. Dr. Curfman's Rio Grande railroad was declared bankrupt, state banks failed and only a handful of patients could afford to be admitted to the hospitals served by Dr. Childs.

Colorado Medical Political Action Committee

P.O. Box 17550 • Denver, Colorado 80217-0550 • 303-779-5455

You're too busy practicing medicine to play politics.

Join COMPAC today and become personally involved in the future of health care in Colorado, **without playing politics.** Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, extension 2427 or 1 (800) 654-5653.

Anita Albrecht
Director, CMS Foundation

Estate Planning: Delight or Dread?

Estate Planning is one of those things that, in polite conversation, we usually do not discuss. Many dread the idea of determining how and what will happen to their estate when they are no longer around. The reality is that no one can predict the future and planning now for what happens to your estate gives you the control. As far as your family is concerned, a will may be the most important financial document you will ever prepare. A will spells out the terms for the distribution of your assets. Because tax laws change frequently and each state has its own unique laws, you may be surprised how things have changed since your will was prepared. A will becomes a public document and is a final legacy to your memory.

During our lifetimes we all accumulate assets. We own houses, cars, property, stocks, retirement investments, collections, and bank accounts. Usually we really don't think about it much, but assets add up. On an average, individuals today have a greater net worth than ten years ago. Everyone has an estate—it is only the amount that varies. And, it seems that when you finally obtain a few dollars, the IRS becomes quite interested in separating you from your holdings. Think of estate planning as a way to take control.

The Internal Revenue Service does reward philanthropy by allowing charitable income tax deductions for gifts made to qualifying nonprofits. Many of the largest charitable gifts in America each year come from estates. Through a number of possible options, distribution from your estate to charity can improve your financial position and maximize your tax benefits.

Regardless of the size of your estate, planning well can give you a chance to influence the future of a charitable organization and make a significant impact with your philanthropy. Maximizing your tax benefits through charitable giving is truly smart philanthropy.

Some Colorado Medical Society members have demonstrated their commitment to the mission of the Colorado Medical Society Foundation through a variety of gift arrangements, such as bequests, charitable trusts, and other special gifts. Gifts such as these are increasingly important to the CMSF mission and make a significant impact on the development of and the future of our programs.

As you consider the many tax-saving options available to you and make the decisions that will shape your estate, please remember the Colorado Medical Society Foundation. The CMS Foundation appreciates, understands, and endorses the commitment you have made to health care during your lifetime and has as its goal, to continue this commitment to health care into perpetuity.

Contributions can be designated for specific CMS programs including the Coalition for the Medically Underserved, the Colorado Rural Outreach Program, and the Colorado Medical Society Education Foundation. For more information, please call Anita Albrecht, Staff Director, Colorado Medical Society Foundation – **303-930-0410.**

Do you have a will? Is your will current? Why do you need a will?

The information in this article is not intended as legal advice. For legal estate planning advice, please consult a tax attorney or financial planner.

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



New Board Members Bring Valuable Business Acumen to the Service of Colorado Physicians

I am very pleased to welcome two new members to the Copic Trust and Copic Insurance Company Board of Directors. Copic is indeed privileged to have such talented individuals working on its behalf. Both of these individuals are highly talented and accomplished in their respective fields of endeavor. They are to be commended not only for their achievements, but also for their willingness to take on a commitment to serve Copic and our Colorado physicians -- a commitment that could extend for as much as twelve years.

Ms. Virginia Berkeley is President of Colorado Business Bank-Denver. In her banking career, she has held positions with United Bank of Denver (Assistant Vice President, Commercial Loan Division); Colorado National Banks (Vice President, Commercial Loan Division; President, CNB-Tech Center and CNB-Northeast; and Vice President/Manager, Business Banking); and Bank One, Denver, N.A. (Senior Vice President/Manager, Business Banking). Ms. Berkeley received her B.S. from Purdue University, where she majored in Economics. She earned her M.B.A. from the University of Oklahoma. Among her many professional and community activities are Board or leadership positions with the Bard Center for Entrepreneurship Development (Leadership Council, 1997 to present); College of Business at the University of Colorado at Denver (Board of Advisors, 1995 to present); Denver Metro Chamber of Commerce (Board of Directors, 1997 to present); Downtown Denver, Inc. (Board of Directors, 1998 to present); Mayor's Business Advisory Council (1997 to present); Mountain States Employers' Council (Board of Trustees, 1998 to present); Women's Forum of Colorado, Inc. (1996 to present); and Women's Vision (Board of Trustees, 1997 to present).

Mr. Robert E. Bigelow is President and CEO of Bigelow & Company Investment Bankers. Mr. Bigelow has a broad background in all aspects of the investment banking industry. He started his professional career with Peat Marwick, rising to the position of Tax Manager. He has also held positions with Kirchner Moore & Company (as head of the Public Finance Department and later as President); Drexel Burnham Lambert (as Senior Vice President and Manager of the Municipal Finance Department); and at Dougherty, Dawkins, Strand & Bigelow (as Vice Chairman). Mr. Bigelow's formal education includes a B.B.A. from the University of Oklahoma and a J.D. in Law from Washburn University. Mr. Bigelow is also a Certified Public Accountant.

I wish to take this opportunity to acknowledge and thank Copic's Nominating Committee for the time and effort they invested in finding such outstanding Board candidates. Special recognition goes to Alethia E. "Lee" Morgan, M.D., Chair of the Nominating Committee, and Barbara R. Reed, M.D., the Committee's Vice Chair.

Ms. Berkeley and Mr. Bigelow will begin their Board tenure in January 2000. They will bring to Copic additional business knowledge and skills, and are eager to work with the other members of the Board to ensure Copic's financial stability and long-term growth. Please join me in welcoming them and in thanking them for choosing to devote a considerable portion of their foresight, acumen, skills and time to the benefit of us all.

Colorado Medical Political Action Committee

P.O. Box 17550 • Denver, Colorado 80217-0550 • 303-779-5455

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Join COMPAC today and become personally involved in the future of health care in Colorado, **without playing politics.** Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, extension 2427 or 1 (800) 654-5653.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

According to Greek mythology, Prometheus was the only deity who befriended the then-despised human race. He paid dearly for his gift of fire, stolen from Mt. Olympus, as eulogized in the well known "Prometheus Bound." It is also reported that he gave a second gift, by removing mankind's ability to see the future with certainty--and in so doing gave us HOPE.

As we enter the new millennium, the physician's role in the future delivery of health care is in great jeopardy. We have been challenged not only by other payers, patients, coding inspectors, and litigious elements--but also by our former allies, including both hospitals and fellow physicians. We are at war, fighting for survival, and increasingly uncertain as to who is friend and who is foe.

Approaching our fifth anniversary, the Colorado Physician Network has thus far survived the perils of the 90's. Our collaborative affiliate, Rocky Mountain HMO, is again profitable after a couple of difficult years. CPN membership in the Front Range is now in the range of 18,000 enrollees--and growing. Efforts are underway to enhance our physician reimbursement fees, and utilization management initiatives are beginning to reduce in-patient expenses. We are investigating other areas of value-added services to our membership in the months ahead.

Yet, much remains to be done. . . .and the future remains uncertain. We are far from satisfied with what has been accomplished thus far, and must approach the months ahead with intensified initiative and commitment. We ask your continued support as we attempt to model "a better version of managed care", based on physician empowerment and patient advocacy.

And let us not despair that we cannot foresee the future with certainty. Thanks to Prometheus, unchangeable fatalism has been replaced with HOPE--and therein lies the opportunity to "make it happen!"

Spirituality & Healing

IN MEDICINE

Under the direction of Herbert Benson, MD.
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Carla Sisk
Department of Human Resources
St. Peter's Hospital • 2475 Broadway
Helena, Montana 59601

Or Call: (406) 444-2119; or
Fax CV to (406) 447-2609

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Attention - Colorado Medical Society Members

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by Marilyn Rissmiller
Program Manager
Division of Health Care Financing

Consultation vs. Visit - HCFA clarifies its interpretation

HCFA (the Health Care Financing Administration) has clarified two long-standing areas of confusion surrounding its definition of consultations: (1) the distinction between a consultation and a visit, and (2) the documentation requirements for the request and the report. Following are the revised consultation regulations that were released last year.

CONSULTATIONS
(Codes 99241-99275)

A. Consultation Versus Visit - Medicare will pay for a consultation when all of the criteria for the use of a consultation code are met:
(1) Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).
(2) A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
(3) After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

B. Consultation Followed By Treatment - Medicare will pay for an initial consultation if all the criteria for a consultation are satisfied. Payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of the referral, and the receiving physician documents approval of care in advance. In this case, the receiving physician would report a new or established patient visit depending on the situation and setting (e.g., office or inpatient).

A physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation*) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.
Note: This is a liberalization of HCFA's policy, previously if the consulting physician assumed even a part of the patient's care at the time of the initial visit it did not qualify as a consultation.

C. Consultations Requested by Members of Same Group - Medicare will pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements (in A. above) for use of the consultation codes are met. (This would generally mean that the physicians were different specialties, although not stated in this section, there would be a question of "medical necessity" if both physicians had the same specialty.)

D. Documentation For Consultations - A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request may be documented as part of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record.

In an office setting, the documentation requirement may be met by a specific written re-

(Continued)

(Continued from previous page)

quest for the consultation from the requesting physician or if the consultant's records show a specific reference to the request (e.g., consultant's staff makes a note in the patient's chart documenting a telephone conversation from the requesting physician's office). In the office setting, the consultation report is a separate document communicated to the requesting physician.

E. **Consultation for Pre-operative Clearance** - Medicare will pay for the appropriate consultation code for a pre-operative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.
* There has also been some confusion regarding the correct use of the follow-up consultation codes (99261-99263). These codes should only be used if another visit is necessary to complete the initial consultation, or if the attending physician requests subsequent consultative services (during the same admission). If the consulting physician is participating in the patient's ongoing management the subsequent hospital care codes should be used (99231-99233).

These changes were to be implemented August 26, 1999, but did not affect claims that were previously processed. If you have any questions, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800- 654-5653, ext. 2428.

Congratulations. . .

. . . to the new President of Denver Medical Society, Dr. Elaine Norman Scholes.


Elaine Scholes, MD

Dr. Scholes was elected to the Colorado Medical Society Board of Directors in 1993 and served two 3-year terms. She retired from the Board in the Fall of 1999.
She scarcely missed a step in going from the CMS leadership to the DMS Presidency.

Dr. Scholes was installed in November in the company of other new DMS officers, including Dr. Louise McDonald, Chairwoman of the DMS Board (currently CMS Speaker of the House of Delegates), Dr. James Regan, President-elect (a charter member of the CMS Young Physicians Section some years back), and Dr. David Downs, Treasurer.

New members of the DMS Board are Dr. Johnny Johnson and Dr. Michael LePore. Returning board members include Dr. Martha Ilige-Saucier, Dr. Robert McCartney (Alternate Delegate from CMS to the AMA), Dr. Richard Allen (President-elect of CMS), Dr. David Campbell, Dr. David Flitter, Dr. Charles Gibbs, Dr. George Kandel, Dr. Bonnie McCafferty (member of the CMS board) and Dr. Stanley Kerstein.

Congratulations, one and all!

CPHP

Colorado Physician Health Program

Dedicated to Physician Peer Health Assistance

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Denver, CO 80203
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1-800-927-0122

CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health Program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

THE CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance

The ***CMS Office Manager*** is a genuine Medical Office Resource.

CMS publishes a bimonthly newsletter dedicated to providing the physician's office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on staff analysis of the problems facing the physicians' offices. The newsletter is free to the office staff of CMS members, Non members can subscribe to the newsletter at a cost of $75.00 per year.

If you are currently not receiving the newsletter in your office, please copy this form, complete it and **FAX** it to Marilyn Rissmiller at (303) 771-8657, or mail it to P. O. Box 17550, Denver, CO 80217-0550.

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Specialty _____

Practice Address _____

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Practice Phone _____

Practice FAX _____

E-Mail Address _____

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Hall of Life™ Health Education Center

Denver Museum of Natural History • City Park • 2001 Colorado Boulevard • Denver, Colorado 80205

Celebrating 25 Years of Health Education

over 4.5 million served

Mission: To provide to people of all ages innovative exhibits and dynamic educational programs that teach how the body functions, that motivate positive health choices, and that emphasize the role of personal responsibility in matters of helth and physical fitness.

History of the Hall of Life: Colorado is one of the few states where health education is not mandated in the schools. The Hall of Life (HOL) was created to help fill this gap with prevention-oriented programs that emphasize the positive impace of healthy lifestyle choices.

1975	HOL was founded by Leo Nolan, MD, of Clear Creek Valley Medical Society as an independent non-profit agency and housed in the Blue Cross/Blue Shield building in Denver.
1987	HOL was merged with and moved to the Denver Museum of Natural History
1989-90	HOL interactive exhibition opened in two phases
2000	**HOL celebrates 25 years of health education in Colorado**

Audience: HOL's audience grows annually and has more than doubled during the last decade. Outreach programming has been its biggest growth area. Following are totals for 1998, the lat complete year.

- **At the Museum**

Exhibition		Visitors	292,000
Programs:	2,277	Participants	92,000

- **Community Outreach - schools, worksites, community events**

Programs:	2,370	Participants	56,800
Health Fair Displays:	211	Participants	48,450

Exhibition

Interactive hands-on exhibits activated by a LifeCard allow each visitor to build a personal health profile with a printout to take home. Exhibits target birth, anatomy, genetics, the senses, and personal choice areas of nutrition, fitness, stress, and drugs. The HOL is enlivened with staff and volunteers who conduct ongoing gallery programs, dissection demonstrations and participatory activities in the 10,000 square foot exhibit space.

Programs

Professional health educators bring health issues to life with programs and health fair displays designed to engage people of all ages. Unique features are bio-mount specimens, medical models, and one-of-a-kind teaching exhibits.

Most Popular Programs:

1. Mastermind (Brain & Helmet Safety)
2. Transplantation
3. New Mc (Puberty)
4. Forensics
5. Healthy Heart
6. Move It (Muscles & Bones)
7. Lung Power
8. Drug Free
9. Sense-Abilities (Five Senses)
10. How Life Begins 1 (Human Development)

The Future - Rising to the challenge of fast-paced discoveries in health science, the Hall of Life will continue to lead Colorado toward a healthier tomorrow

Sponsorship/Endorsement: The **Colorado Medical Society** and **Colorado Medical Society Alliance** have endorsed the Hall of Life since 1980. The **Denver and Colorado Medical Society Alliance** have continually sponsored Hall of Life programs and exhibits, particularly in providing scholarships for children of low-income families.

Hall of Life

What impact do Hall of Life programs have on children's knowledge, attitudes and health behaviors? Do they think about or apply what they learned after class? Do they talk to their friends and families? The following are excerpts from letters they write to the Hall of Life expressing in their own words what was memorable to them.



I think a lot of kids in my class learned a lot and enjoyed seeing what was preserved in the jars like the part of the eye and the lungs. It is most likely the only time I will ever get to see something like this. —Stephanie

I thought it was totally Awesome when you brought the sheep brain to my school. It was the third place in the best days of my life. Sincerely, Parrish

I liked the Hall of Life because it showed how our lungs work. She had an interesting way of showing the way smoking hurts your body and how it feels to have asthma. It makes me want to be a doctor. –Sarah

You taught me something I wanted to know for a long time. I won't do drugs or drink vodka and alcohol because I know it is bad for you and other people too. Thank you, - Katie

You taught us things in the coolest ways I've ever seen a teacher teach. I really liked it.
–Richard

I like the Hall of Life probably the most out of everything. It gives us a funner way to learn..Now I'm never going to smoke or chew tobacco. Now I really know why your shouldn't do those two things.
– Eric

Important Message Regarding the Medicaid Primary Care Physician Program

The Colorado Medical Society (CMS) has received a copy of a letter from the Colorado Department of Health Care Policy and Financing (CDHCPF). This letter was sent to some of the larger PCPP practices to inform them about potential policy and legislative changes in the PCPP. Based on the information that CMS has received, we are opposed to these changes. We feel that Medicaid clients should have the right to choose the PCPP or an HMO. Medicaid clients mandated to enroll in an HMO may lose their ability to see the physician of their choice. Please read the following letter, and share your thoughts with Mike Chisholm the PCPP Administrator at the CDHCPF. CMS would also like to hear your comments. Please send your comments to Edie Register.

As a participating physician in Colorado Medicaid's Primary Care Physician Program (PCPP), you need to be apprised of potential policy and legislative changes that could affect your medical practice. This communication is an effort to inform you that there could be significant changes in the PCPP on the horizon.

Background: As directed by statute, the Department has been investigating the feasibility of competitively bidding HMO services to Colorado's Medicaid population. In addition to the additional savings, a competitively bid program creates the opportunity to offer managed care services on a statewide basis. The statewide model provides the opportunity to increase access to services in underserved rural areas of Colorado.

Based on the experience of the Department's consultant on the project (Mercer, Inc.) and feedback from potential bidders, it was determined that the Primary Care Physician Program (PCPP) creates an environment where competitive bidding is unlikely to succeed. In order for competitive bidding to be viable, sufficient, known quantities of clients must be available for enrollment in managed care organizations. If the PCPP is available to all clients, the necessary conditions for competitive bidding cannot be met.

Analysis of quality assurance measures by the Departments found that the PCPP lacks the ability to address quality measures important for the general population and for some chronic conditions.

Neither the PCPP nor any fee-for-service coverage offers preventative benefits for adult Medicaid clients. It is estimated that addition of preventative benefits to the fee for service delivery system would cost approximately two million dollars annually for a basic set of services. HMOs are mandated to *offer* preventive benefits at no additional expense to the state.

Retaining the PCPP as an option for all categories of aid does not address the legislature's request for increased savings or recent findings concerning quality of care and access to preventative benefits. The Department will have to decide if maximizing choice must include maintaining a fee-for-service option for Medicaid clients. In all future scenarios the issues of quality assurance and preventative benefits for the PCPP will need to be addressed

Proposed Scenario: PCPP for Special Needs / HMO for all other Medicaid Categories

Due to the significant savings generated by the PCPP for the AND/SSI category it would be cost effective to offer continued service to this category by the PCPP. Special needs clients would still be able to choose Medicaid HMOs if they desire. If the county in which you practice has a Medicaid HMO, you would need to work such an HMO to continue seeing all other general categories of Medicaid Clients.

Practice Ramification: Under the proposed scenario, PCPP medical practices that are in the affected counties would be required to affiliate with at least one HMO serving Medicaid clients in order to continue serving clients other than those with special needs. In this scenario these patients will either be converted into members of a specific Medicaid HMO (with physician's approval), or they will be defaulted into a Medicaid HMO through existing processes.

These medical practices can either pro-actively negotiate with Medicaid HMOs or they can allow most of their Medicaid PCPP patients to be served elsewhere.

All future scenarios for the PCPP will include quality improvement efforts.

Please provide us with your thoughts on these proposed changes by returning the accompanying survey to my attention. Or, if you would like to further discuss these possible changes, feel free to contact me (**Michael Chisholm, PCPP Administrator**) at 303-866-5947.

CPT 2000

There have been a number of changes in the coding for automated multi-channel chemistry panels (80048-80092) in the ***CPT 2000.*** Five new organ or disease oriented panel codes have been added while six of the existing codes were deleted. The Health Care Financing Administration (HCFA) has announced that Medicare will not be able to process any claims with the 2000 changes until April 1, 2000. Because of their Y2K focus, they will not be able to update their systems in time to use these codes beginning in January. However, these are the only *CPT 2000* changes they will not be ready for, so you need to compare the codes you use regularly to those in the new CPT. Check to see whether any of your old favorites have been deleted or revised, or if there are new codes about which you should be aware.

Don't panic if you can't find the laparoscopic codes (56300-56399), they've been moved. The code numbers have been changed and they are now included in the appropriate anatomical section of the surgery codes. (See examples below)

Part of the CPT process is to provide additional clarification, through new or revised codes and explanatory notes, for areas in which there have been problems with interpretation. A number of such changes have been made in the spinal section of the musculoskeletal codes, throughout the cardiovascular surgery section and the nervous system. There have also been changes in the facet joint and facet nerve injection codes (64622-64627) so they better reflect the current use.

It is important to incorporate the ***CPT 2000*** changes into your billings to avoid delays or denials. However, ***timing is everything.*** Most insurance carriers, including Medicare, give you a grace period before use of the ***CPT 2000*** codes become mandatory. For Medicare that grace period is 90 days. If you're not certain about your other insurers, check with them. Using the codes too soon can cause just as many delays as using the old codes too long.

If you have any questions, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653, ext. 2428.

Examples of Coding Changes

New Code		***Old Code***
44200	Laparoscopy, surgical; enterolysis	56310
47562	Laparoscopy, surgical; cholecystectomy	56340
58671	Laparoscopy, surgical; w/occlusion of oviducts	56302

Colorado Medicaid Program is Ready for Y2K

According to an ongoing review by the Health Care Financing Administration, the Colorado Department of Health Care Policy and Financing (CDHCPF) is confident that its computer systems will continue to process payments for medical providers, including hospitals, physicians and pharmacies.

At this writing well before the 24:00.01/2000 event, we can only report what has been said at CDHCPF. Executive Director Jim Rizzuto said that "Medicaid clients should continue to get the health care they need and providers will be able to use the computer billing system and get paid." He added that "If there are any glitches, and I do not anticipate any during the New Year's Eve transition, they will be the result of other systems outside ... having problems or failures. This agency has contingency plans in place."

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING
November 19, 1999

A. AMA Delegation:

Dr. Richert Quinn reported that the delegation is in the process of getting ready to attend the AMA interim meeting in San Diego. The meeting convenes on December 5, 1999. He stated that the delegation has submitted several resolutions to the AMA, some of which were adopted at the CMS annual meeting. Dr. Quinn stated that the AMA has implemented a fraud and abuse education program on their web site. Ms. Terry Burke stated that the AMA has signed agreements with Intel to obtain digital certificates for privacy over physician's e-mail, and have collaborated with six specialties for a patient/physician web site.

B. Colorado Physician Network (CPN):

Dr. Jeremy Lazarus stated that CPN is looking forward to the open enrollment period, and is hoping to have 24,000-25,000 members by January.

The Board discussed Resolution 16-P "State Action Doctrine for Collective Negotiation" (referred to the Board of Directors Reference Committee at the 1999 CMS Annual Meeting) at length. The resolution, introduced by Clear Creek Valley Medical Society and the Colorado and the AMA Delegation, which read as follows:

WHEREAS, managed care has continued to consolidate in the Colorado marketplace concentrating patient populations in fewer and fewer health plans, and

WHEREAS, due to their market power, many health plans refuse to negotiate specific contract provisions with individual physicians, and

WHEREAS, some contract provisions restrain physicians from being able to advocate for the best possible medical care for their patients, and

WHEREAS, anti-trust law currently prohibits self-employed physicians from negotiating collectively with health plans, and

WHEREAS, the State of Texas recently passed legislation that became law creating a State Action Doctrine to permit physicians to negotiate collectively under the supervision of the State of Texas, and with health plans would help to "level the playing field" for physicians in dealing with health plans, therefore be it

RESOLVED, that the Colorado Medical Society (CMS) support introduction of legislation in the next session of the Colorado Legislature to create a State Action Doctrine that will permit physicians to negotiate collectively with health plans, and be it further

RESOLVED, that all activities of our Colorado Medical Society regarding negotiation by physicians maintain the highest level of professionalism, consistent with the AMA and CMS Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs, specifically Policy E-9.025[1], and be it further

RESOLVED, that CMS give-such legislation the highest priority for passage, and be it further

RESOLVED, that CMS involve state specialty societies and other health care providers as appropriate in creating a coalition to lobby for passage of such legislation, and be it further

RESOLVED, that CMS call upon the assistance of the American Medical Association (AMA) in writing and passing this legislation.

A questionnaire was sent to all of the health maintenance organizations in the state to ascertain the success of cooperative efforts between the Colorado HMO Association (CHMOA) and CMS. According to the survey, to date, these efforts have been successful.

Ms. Maloney presented to the Board the following options for consideration: to not pursue legislation at this time and continue meeting with the CHMOA, or to pursue legislation during the 1999-2000 legislative session. The Campbell bill (national legislation) has been resurrected, and if it passes, individual states will not have to implement legislation to create their own state action doctrines. CMS leadership feels that because of the success of the collaborative efforts between the CHMOA and CMS, and because of the possible passage of the Campbell bill, that CMS does not need to seek legislation at this time.

The next board meeting will be held on January 21, 2000 at the Colorado Medical Society offices.

Lynn Painter
Colorado Medical Society Alliance

Your Voice is Our Power

As we enter the new millennium, it is clear that health care legislation at both the federal and the state levels will continue to dominate the political landscape. This intense focus is driven by skyrocketing health care costs, and shrinking health care dollars ... therefore our involvement as physicians' spouses, as physicians, as parents, as patients, and as community leaders has never been more important.

The year 2000 Presidential Campaign will provide the family of medicine with an excellent opportunity to be part of the ongoing national debate over health care and to define the health care issues for the candidates.

Plan now to attend the CMSA Legislative Day at the Capitol on Friday, January 28, 2000 to hear an update on the issues most important to patients and physicians, and then discuss them with your legislators themselves at the breakfast. All activities are open to all CMSA and CMS members.

We are honored to have Congressman Scott McInnis join us at lunch to offer a Washington update. He will be with us for about thirty to forty minutes and has asked us to prepare a list of topics we would like him to address. If you have special concerns or would like more information on an issue or you have a suggestion for a topic for the Congressman, please contact Suzanne Hamilton at CMS (303-779-5455) or fax your questions to Lynn Painter at 303-534-0577.

We have planned a very special day for you. Advocacy is defined as an act of pleading a cause; recommending; interceding; or upholding. Grassroots advocacy, therefore, is simply making your voice heard. Medicine can no longer afford to approach the legislative process with only a strong lobbying program and an effective PAC federation. Lobbyists must have a broad base of political support for the legislative positions taken. That support is based on informed views expressed by constituents who share the same concerns on the issues ... and that's **YOU**. Politicians know that "all politics is local" and they must "vote their district." That's why grassroots action is so effective. Your elected officials want to hear from you because they want specific examples of how an issue would effect you.

A strong presence is needed at the Capitol on Friday, January 28 to deliver medicine's message. Get the word out to your county alliance and medical society members and encourage their attendance. Make your reservations early so we can ask as many legislators to join us as possible.

Schedule of Events

8:00 a.m. - 9:30a.m.
Breakfast with your legislators
A great time to meet your legislators
Coffee, Fruit and Danish
Outside the old Supreme Court Chambers

9:30 a.m. - 11:00 a.m.
Legislation Education
Health Issues
Pending Health Legislation
Election Year 2000
Old Supreme Court Chambers

LEGISLATIVE DAY AT THE CAPITOL Friday, January 28, 2000

11:45 a.m.
Lunch **$20.00 per person**
Adams Mark Hotel - Windows Room
Please invite your legislators to join you for lunch
SPECIAL GUEST SPEAKER – CONGRESSMAN SCOTT MCINNIS
Please arrive promptly as Congressman McInnis will only be able to join us for 30 minutes.

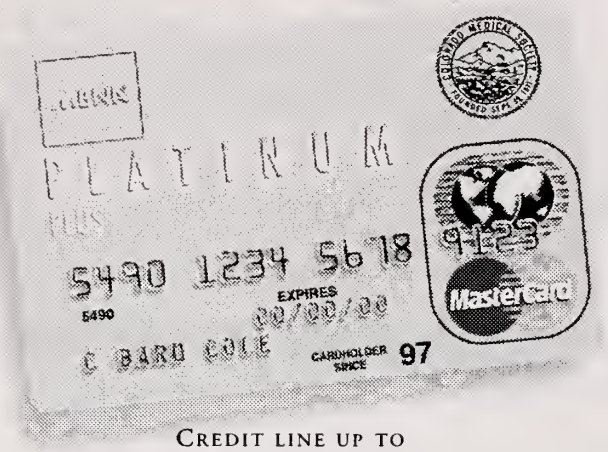
5:30 p.m. - 7:00 p.m.
CMS Cocktail Reception
A great time to meet old and new friends and discuss politics.
Starkey Institute, 350 Logan Street
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7:30 p.m.
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GV4T
JM-94
V8

Name _____ Social Security # _____ Birth date _____ Mother's maiden name _____

Address _____ City _____ State _____ ZIP _____

Monthly housing payments $ _____ Are you: ☐ Homeowner ☐ Renter ☐ Other

Home phone (___) _____ Business phone (___) _____

Employer _____ Position _____ Years there _____ Source of other income‡ _____

Please send an additional card at no extra cost for: _____ Relationship: _____

Your annual salary $ ___,___

Other income‡ +$ ___,___

Total household income $ ___,___

‡Alimony, child support, or separate maintenance inco need not be revealed if you do not wish it considered a basis for repayment.

X _____ Date ___/___/___

MY SIGNATURE MEANS THAT I AGREE TO THE CONDITIONS APPEARING ON THIS FORM.

Please complete only if you have moved or changed employers in the last three years.

Previous Address _____ City _____ State _____ ZIP _____

Previous school or employer _____ Years there _____

Annual fee	None.
†Annual Percentage Rate (APR)	14.99% fixed for purchases.
Grace period for repayment of balance for purchases	At least 25 days, if each month, we receive payment in full of your New Balance Total by the Payment Due Date.
Method of computing the balance for purchases	Average Daily Balance (including new transactions).
Transaction fees for cash advances and fees for paying late or exceeding the credit limit	Transaction fee for Bank and ATM cash advances: 2% of each cash advance (minimum $2). Transaction fee for credit card cash advance checks: 1% of each cash advance (minimum $2, maximum $10). Late-payment fee: $25. Over-the-credit-limit fee: $25.
Transaction fee for purchases	Transaction fee for the purchase of wire transfers, money orders, bets, lottery tickets, and casino gaming chips: 2% of each such purchase (minimum $2).

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The current promotional Annual Percentage Rate (APR) offer for cash advance checks and balance transfers made with either account is 5.9% through your first five statement closing dates, commencing the month after your account is opened. When your minimum monthly payment is not received by the close of the first complete billing cycle following its Paymen Due Date, or when the promotional offer expires, whichever occurs first, the APR that will b applied to both new and outstanding cash advance balances (consisting of cash advance check and balance transfer transactions) will be 14.99%. MBNA may allocate your monthly payments to your promotional APR balance(s) before your nonpromotional APR balance(s)

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Unless I write to MBNA at PO Box 15342, Wilmington, DE 19850, I agree that MBNA and its affiliates may share information about me or my account for marketing and administrative purposes. I am at least 18 years of age. I consent to and authorize MBNA and its affiliates to monitor and/or record my telephone conversations with any of their representatives to bett ensure quality service. **I understand that if this credit card application is approved for an account with a credit line of less than $5,000, I will receive a Preferred Card.**

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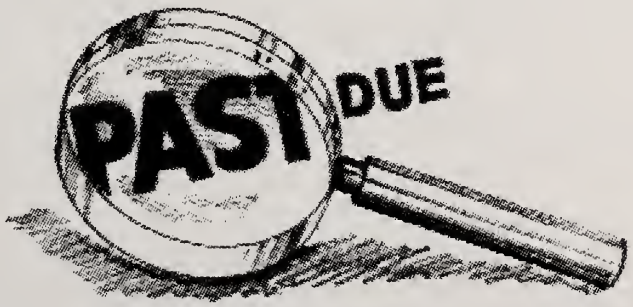
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Chet Seward
Director, Division of Health Care Policy

CMU Data Subcommittee gets health care financing pointers from Oregon

Lessons from Oregon

- The prioritization process can assist in developing a more rational health care financing system;
- De-link health care service prioritization process from politics;
- Engage the community;
- Involve providers and the business community from the start; and
- Seek incremental change.

Lofty goals spark creative thought. And so it goes as the Coalition for the Medically Underserved (CMU) pursues its goal of achieving health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007. The CMU Data Subcommittee has been charged with developing financing models that can sustain all of the coverage necessary under that ambitious goal. Under the expert leadership of Barbara Yondorf, the subcommittee has analyzed the strengths and weaknesses of various systems in its attempt to construct an efficient, effective and affordable system to provide care for all of the state. The first step was to build upon the research used to develop *A Plan for Colorado.* The second step has been to learn lessons from the efforts of other states. Last month the Data Subcommittee received some valuable advice from Mark Gibson, Policy Advisor for the Office of Health Care, Human Services and Labor to the Honorable John Kitzhaber, Governor of Oregon. The meeting proved to be informative for both Mr. Gibson and subcommittee members. It also helped to push the committee into phase three by focusing efforts on developing a number of different financing system models for Colorado.

Oregon is a forerunner in health care reform. The state has pursued innovative strategies and has a strong commitment to the medically underserved. The Oregon experience is relevant to Colorado because of its similar size, politics and geographic dispersion of the population.

Mr. Gibson presented an overview of health policy reform efforts and the Oregon Health Plan (OHP) to the subcommittee. The goal of the OHP is to improve the health of all Oregonians and assure access to health care. Thus the plan is about health and *not* just health care. To date their focus has been on ensuring coverage for all Oregonians.

Oregon has received considerable fanfare and criticism regarding its prioritization efforts. The state has developed a prioritized list of medical procedures that are covered by public insurance programs. Mr. Gibson noted that the intent of prioritization was to promote conscious decision making about the benefits package. He stessed that the reform process raised questions about the traditional role of insurance (spreading risk) versus the role of public health. The end result of the process was an increased awareness about the need for and value of health and health care. OHP has succeeded in lowering the number of uninsured. However, there are growing access problems prompting debate regarding the effectiveness of the insurance model. According to Mr. Gibson, the key to addressing the gap in coverage between public and private insurance is a public and private partnership.

The OHP must be viewed as a framework to understand limitations and possibilities for future change. It represents more than just a Medicaid rationing process. Direct results of the program include: small group insurance reforms; the creation of an uninsurable risk pool; the establishment of numerous patient protections; the development of a family health insurance subsidy program; and a drop in uninsurance rates from 18% in 1990 to just over 11% in 1999.

The Oregon experience provides valuable lessons that can be applied to reform efforts in Colorado and build momentum for Coalition initiatives. If you wold like more information regarding activities of the Data Subcommittee, please contact staff at 303-930-0426.

COLORADO
Coalition for the Medically Underserved

Save the Date

FOURTH ANNUAL CARING FOR COLORADO'S MEDICALLY UNDERSERVED CONFERENCE

Friday, March 3, 2000
8:30 a.m. - 4:30 p.m.

Radisson Hotel Denver Stapleton Plaza
3333 Quebec St., Denver, CO

Keynote speakers include:
Henry Simmons, MD
President, National Coalition on Health Care

Marilyn Gaston, MD (invited)
Assistant Surgeon General, Associate Administrator for Primary Care

Mark your calendars to attend a dynamic, regional conference focusing on health care, health insurance coverage, access to health care and the needs of the medically underserved. This year's program will be better than ever. We've used the comments and evaluations from past conferences to improve the program. As usual there will be lots of new information and many opportunities to learn, network and recharge your batteries!

Similar to years past, an awards ceremony honoring three people that provide outstanding service for the medically underserved will be held. Nomination ballots will be included in the conference registration information. Also returning again will be the ever-popular poster contest for local programs serving the medically underserved.

Panels and breakout sessions will include:

- An analysis of various financing models developed by the Coalition to assure that by 2007 all Coloradans will have health insurance coverage
- Grassroots approaches to increase legislative advocacy, maximize community resources, communicate with the media and raise awareness about the underserved
- Community approaches to addressing the needs of the underserved
- Evaluating current statistics and the effect of reforms on the medically underserved
- Personal perspectives from medically underserved individuals
- Legislative update on activities at local, state and federal levels

Look for conference registration details in the February issue of Colorado Medicine. **Save the date now!**

2000 Colorado Science and Engineering Fair

April 13-15, 2000



Artist: Shalini Therese Lon-Nam,
Boulder High School

Wanted:

Two physicians willing to devote one-half day in April, 2000 (on Thursday) to judging the health science entries in the 2000 Colorado Science and Engineering Fair. These physicians will be representing the Colorado Medical Society Education Foundation and the medical profession in Colorado. Judging is fun and not difficult (except that some times the choices are hard between some of the top-flight student projects). Judges will be provided auto travel and meal expense, free parking on the CSU campus and complete instructions on judging.

The Science Fair has been a sponsored project of the Colorado Medical Society (CMS) and the CMS Education Foundation (CMSEF) since the Fair's inception. If you would be willing to participate, please contact either Sandy Finney, CMSEF, or Bill Pierson, CMS, at (303) 779-5455, or 1-800-654-5653

If you have a practice website, it can be linked to the Colorado Medical Society web page. AND. . . we'll do it for you! No muss. No Fuss. No cost.

If you're thinking about ways to market your practice in these days of high-tech anything and everything, then the Internet is probably where your practice belongs. If you currently have a web page for your practice, then this is a way to make you and your practice more accessible, more recognizable and certainly more available.

Here's all you do:
Complete the little form on this page, send it in to CMS, and we'll take care of the rest, at no charge to our members.

Here's how it works:
We go to the CMS "Member Locator" on the web, select your name, and add the link right there, under your name, to your web page. This is a new world of marketing and communications, and you should be at the forefront.

We have been making this member service available for the past five months, and now that more and more practices are becoming very Internet-literate, it's time for you and your physician associates to be out front with your consumer-oriented medical care information.

Just what's the value of your being on the world-wide internet? Are there patients out there in cyberspace that might come to you? We don't actually know the answer, but it IS rather doubtful. However, there's a whole new world of information of all sorts that can be gathered in "bits and pieces."

The Internet is all about exchange of informtion. Your practice goes "on line" and another physician sees it and suddenly knows a great deal about your practice. He/she has similar interests, problems, solutions and cures. You get together and suddenly you've found a new approach to something in your own practice.

Is your practice ready to "Go On Line"?

People move to Colorado at an excessive rate, and when they get here they don't have a personal doctor. What better way to find one than through your own practice web page, where you can tell them about your medical offices, clinic, etc. The inflow of new residents is expected to continue well into the new millennium, so you should be at the forefront of information dissemination as well as gathering. The Internet is the obvious vehicle for today. CMS will help you use it to your best advantage. Complete the form below and send it back to CMS. We'll do the rest to launch your medical practice into the new age.

Complete this form and mail to: **CMS Communications & Member Services**
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Denver, CO 80217-0550

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URL http//www. _____

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FAMILY PRACTICE Near Boulder. Independent group seeking third partner with OB. Excellent, flexible climate. Fax CV to (303) 425-9259 or contact Rob Hurlow, MD or Leif Redal, MD (303) 425-9581. 04/1199

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RUMINATIONS

(**def:** chewing again what has chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

On December 31, 1999, the Panama Canal was passed to Panamanian ownership.

From October 1, 1996 to September 30, 1997, 14,747 ships of all sizes transited through the Panama Canal. 9,716 of them were commercial oceangoing ships.

As you read this, ownership and control of the Panama Canal has just passed into the hands of the Panamanian government. We've had a good thing going.

The Canal is, indeed, an engineering marvel. Prior to seeing it, I could not conceive what this waterway and the canal locks were capable of handling. And the Canal has been in steady use since 1914.

In WW II, the Panama Canal was a vital sea link, particularly for the U.S. At that time, a good friend of mine was a Captain (youngest Captain) in the U. S. Merchant Marines, and he was sailing a freighter to the middle and far east from Atlantic and Gulf ports. In 1942 he was on his way through the canal to the Pacific, smack in the Miraflores Locks, when he got an urgent radio message to turn the ship around and head back to the south Atlantic where he was to join a convoy to Europe. His ship and contents were being diverted because his was the only civilian ship in the area with any armament (one 20mm cannon on the bow), and a German submarine, they thought, had been spotted in the South Atlantic. He was certain the gun was inoperably rusted and corroded, but as soon as he got the ship into the Pacific, he hauled her around and headed back north. This time, when he got into the Gatun Locks he was told by radio that his orders had been changed, and he would continue on his Asian course. The ship passed Colon; he cranked her around again and headed south, getting to Gatun Lake, when another crackling code message ordered him back to the Atlantic. Back he went through Gatun Locks and into the Atlantic, where he joined the convoy and sailed to Europe. His ship was a small freighter by today's standards, so passage through the canal was as fast as any ship could make it. When all was said and done, he had been through the canal three times in one day, a record for those years. The record may still stand. Fortunately, my friend the Captain was never called on to try to fire the gun.



Gatun Locks. . .Container freighter - 800' in length, less than 5' to spare from side to side. Not a scratch.



Control room of the Gatun Locks on the Panama Canal. Vertical gauges tell the depth of the water in each of the three locks.

To me, the control of the Canal has always been a pretty tricky balancing act. You don't understand the mechanics of our 85-year operation of the Canal until you see it firsthand. The Panama Canal Zone is a U. S. military zone in a foreign country, there to see to the security of the Canal and all its trappings.

When I was in Panama I was warned that the Panamanians didn't much like Americans, but they liked American dollars. Some Panamanian women, they said, would go to extreme lengths to establish a 'quicky' relationship with the gringo and his money. I was advised to be absolutely certain that my cottage door was securely locked at night, or I might find a strange female in my bed or in my trouser pockets.

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Believe me, **NOTHING** happened!

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Are you in the picture?

Colorado Medical Society Foundation makes grants to health care centers throughout the state.

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e award recipients are saying:

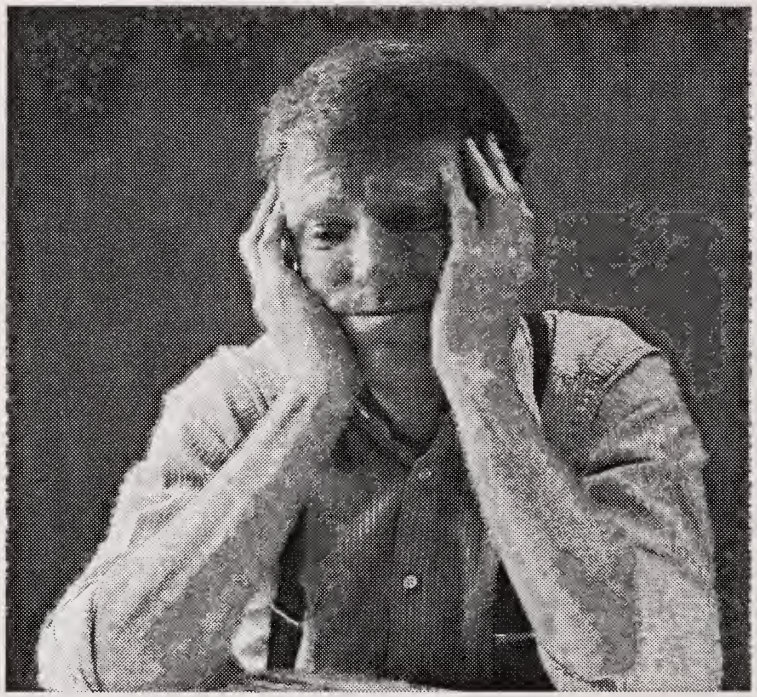
(H) "We are badly in need of this equipment and will utilize your (CMS Foundation) funds accordingly."

Toloa Pearl, Administrator
West Custer County Hospital
Westcliffe, Colorado

See Page 51 for Foundation report.

n This Issue:

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COLORADO MEDICINE

February, 2000 **Volume 97, Number 2**



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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7800 E. Dorado Pl., Englewood, CO 80111. Telephone (303) 779-5455. Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

It is time for physicians to examine our country's health care system, determine what is wrong with it and work aggressively in the political arena to fix it. The assertion that our health care systems are critically ill would engender little debate despite the fact the best medical care in the world is available in the United States. One of the major parts of the problem is that appropriate health care is not available equally to all.

With rapidly increasing numbers of uninsured and disparate systems insuring the poor and the elderly, we in fact are rationing care in a most unethical manner. Examined critically, our present system provides all of health care to the privileged (the insured) and little, none, or at best delayed to the increasing numbers of the uncovered. Are we to continue to provide all of medicine for some or will we wake up and demand the best and most appropriate of medicine for all?

In this egalitarian society we idealize as the United States of America, I believe the answer must be the latter. Whether health care is a right or a privilege matters little, what does matter to us ethically is that it be available equitably to all. How can this be accomplished? As my good friend Denise Denton with the Colorado Rural Health Center said recently, "The devil is in the details. Once we have decided universal health care coverage is the given, surely we in society and government are smart enough to figure out how." And, while we are at it, why not try to design a system that allows patients and physicians to function interdependently in their relationships with the resultant positive therapeutic effects medicine has long recognized.

What might be the features of such an effective and appropriate medical system? Many wise people across our country are considering these issues in organized medicine, in academia, in think tanks and other forums and they are writing about it. Some of the most reasonable ideas follow; I believe they merit consideration.

- To work well, a system providing universal coverage for all should include every U.S. citizen under a single uniform health care program for rich and poor, young and old, federal employees and the unemployed. In other words, everyone, one system, one risk pool, mandated just as auto insurance is mandated now. This could be accomplished through a system of vouchers, tax credits or other types of subsidies pro rated by income so that individuals, not employers or other entities could purchase their health coverage from private entities. Employers could participate if they chose by making a defined contribution for basic benefits. Most importantly individually owned and purchased health insurance could restore patient choice regarding benefits, type of private health plan and their physician.

Demand the best and most appropriate of medicine for all.

- Does a single uniform system mean single payer? Not necessarily, if it is designed around a private health care insurance industry and individual purchase by choice from one of those plans. What might government's role in this system be? Lets hope our leaders have learned from the mistakes of other countries and our own

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government's attempts at administering and managing large enterprises such as health care and the postal service. I would hope government's role would be in defining and mandating the program and then in regulation of the health plans so they would function effectively for patients and physicians (a utility model?).

- Resources are not unlimited. Any health plan that provides coverage for all must include a system of prioritization of available health care resources so that the most effective medicine can be provided for all. Anything more is a matter of individual responsibility. Call this rationing if you wish, but I believe a system such as Oregon's is much fairer than what we have now, rationing by exclusion. I do believe we must help our leaders understand that the very best medicine for all may cost more than they have been willing to spend for it in the past.

This represents radical thinking and would entail radical action and reform of our health care system. I believe our national and state leaders are beginning to realize the problems in health care delivery are severe and getting worse and at stake is sound health care for all Americans. Does the political will exist to make any of this happen soon? My wife says I am naive to think so and she may well be right. But one major presidential candidate is already making overtures regarding major health reform. The AMA, your most effective political lobby, is seriously considering and endorsing many of the above concepts. The AMA is also prepared to demand each presidential candidate delineate his plans for health system reform before the election.

I believe previous attempts to reform health care failed because they were ill conceived because they intentionally ignored and eliminated input from physicians, the medical community and organized medicine. We must make our leaders understand that, as our patients' advocates, no other entity is better qualified to design an effective health care system. As physicians we must be heard and must not pass up this opportunity to be politically active as our country tries to remedy the problems that have made our systems of health care delivery so ill. It seems to me radical and innovative reform is the only way. Piecemeal and fragmented remedies are only going to perpetuate and exacerbate physicians' and their patients' problems.

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by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Peer Review Immunity Under Attack

by Robert Spencer

On December 9, 1999, the Colorado Court of Appeals decided the case of Nicholas v. North Colorado Medical Center[1]. The case is important to Colorado physicians because of its impact upon peer review immunity.

The news is both good and bad. The news is good because the court finds that peer review in Colorado is a form of "state action." That is important because "state action" is necessary in order for peer review to be immunized from lawsuits alleging violation of the antitrust laws. The news is bad, however, because the court finds that the same "state action" which creates antitrust immunity also creates potential liability for violation of the federal civil rights laws, notably 42 U.S.C. § 1983. The news is even worse because the court also finds that state and federal "good faith" immunities are lost if there has been a failure to afford the reviewed physician adequate due process during the peer review.

A summary of the facts in Nicholas will put these points into context. Dr. Nicholas was an invasive cardiologist with provisional privileges at NCMC. When questions arose about his competence to safely perform cardiac catheterization procedures, the Credentials Subcommittee directed that Dr. Nicholas' cath lab privileges be summarily suspended, and recommended that his privileges be further suspended for a year. Dr. Nicholas requested a formal hearing before a panel of three physicians. The hearing panel generally cleared Dr. Nicholas of wrongdoing (except for some record-keeping issues), and recommended only that his practice be proctored for a year. The matter was reviewed next by the House Committee of the NCMC Board of Directors. Despite the favorable recommendation from the Fair Hearing Panel, the House Committee adopted the Credentials Subcommittee's original recommendation that Dr. Nicholas' privileges be suspended for a year. The Board of Directors approved this recommendation.

Dr. Nicholas then sought relief from the state agency known as the Committee on Anticompetitive Conduct. The Committee is an arm of the Board of Medical Examiners, and is empowered to review and reverse peer review actions which involve unreasonable anticompetitive conduct. After a hearing, the Committee determined that unreasonable anticompetitive conduct had occurred, and ordered the reinstatement of Dr. Nicholas' cath lab privileges. Dr. Nicholas then sued NCMC, its Board of Directors and a number of administrators for violation of his federal civil rights, and under state law for tort and breach of contract claims.

Upon motion of NCMC, the trial court dismissed Dr. Nicholas' claims on several grounds. First, it held that Dr. Nicholas could not proceed on his theory that NCMC had violated his federal civil rights because the statute which creates that right to sue (42 U.S.C. § 1983) requires state action. The trial court found the necessary state action lacking because NCMC is a private nonprofit corporation, and not a government facility. The court of appeals disagreed. It held that because a hospital's peer review function is an extension of the authority of the Board of Medical Examiners and is both mandated and regulated by the Colorado Professional Review Act ("CPRA"), it is state action for the purposes of federal civil rights law. The court noted, "[I]ronically, this statutory scheme insulates physicians from antitrust liability arising from their participation in peer review proceedings, but also makes them state actors for the purposes of § 1983." Thus, while CPRA may have been

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successful in creating the state action necessary to provide immunity from antitrust liability, it appears to have created another type of federal liability in its place.

The trial court also dismissed Dr. Nicholas' state law tort and contract claims on the grounds that NCMC, and its board and staff, were immune from liability due to the good faith immunity provisions found in the CPRA and the federal Health Care Quality Improvement Act ("HCQIA"). Again, the court of appeals disagreed. It held that to be entitled to immunity under these state and federal laws, peer reviewers must not only act in good faith, but must also comply with all procedural due process requirements required by federal and state law. In this case, the court found that Dr. Nicholas' due process rights were violated because one of the members of the Credentials Subcommittee that had investigated Dr. Nicholas' conduct and recommended sanctions was also a member of the House Committee which heard the appeal and recommended a final decision. The court held that this member's dual responsibility improperly co-mingled the investigative and adjudicative functions. In the court's opinion, Dr. Nicholas' case had not been determined by an entirely unbiased body, and therefore his due process rights had been violated. Finally, the court held that because the peer review process had not met procedural due process requirements, the defendants were not entitled to invoke the statutory immunity provisions.

Although Nicholas extends federal civil rights law to private hospital peer review proceedings, this portion of the decision does not greatly impact peer review immunity. This is true because good faith is a defense to liability for § 1983 civil rights violations. That is to say, peer reviewers acting in good faith will not be held liable for civil rights violations even if they have failed to comply with all procedural due process requirements. An actor's good faith, however, is generally something than can only be determined by a jury after a trial. Therefore, though good faith should insulate peer reviewers from liability for federal civil rights violations, it may be necessary to endure a lawsuit and trial before the immunity is realized.

The aspect of Nicholas which deals with state law tort and contract causes of action threatens a greater impact on peer review immunity. It appears that good faith alone is no longer sufficient to enjoy immunity from these types of claims, if there have been procedural shortcomings. A peer reviewer who is acting with the best of motives may not be immune from state law claims if the peer review process has not met all procedural due process requirements. The problem of co-mingling peer review functions, as they were in Nicholas, is but one example of conduct which might void the peer review privilege. The court of appeals' opinion, however, suggests that any failure to comply with procedural requirements may be sufficient to void the immunity. Other procedural requirements, found in CPRA, which might trigger loss of immunity if violated, include:

- peer reviewers must make reasonable effort to obtain the facts of the matter.
- peer reviewers must act in the reasonable belief that the action taken is warranted.
- the physician being reviewed must receive reasonable notice of the hearing, have the right to be present, to be represented by counsel, and to offer evidence in his own behalf.
- the physician must be given a copy of the hearing panel's recommendations, shall receive reasonable notice of the right to appeal to the governing board, shall have the right to appear before the governing board, to be represented by counsel, and to offer argument on the record.
- the peer review proceeding must be conducted in conformity with the hospital's bylaws.

Nicholas is not the first case to find that good faith, standing alone, may not be enough to guarantee peer review immunity. Another example of this view comes from a 1996 federal court case from New Mexico, Brown v. Presbyterian Health Services[2]. In Brown, the court addressed the HCQIA requirement that peer reviewers make a "reasonable effort to obtain the facts of the matter." The hospital in this case revoked Dr. Brown's obstetrical privileges based upon only two instances of substandard care. Dr. Brown contended that the peer review action was really motivated by a desire to eliminate competition, and presented expert testimony that a review of six months worth of her patient charts disclosed no substandard care. The court held that, under the circumstances, a jury could reasonably conclude that the hospital had not made a "reasonable effort" to obtain the facts. In the absence of a reasonable effort to obtain the facts, the peer reviewers had not complied with the procedural requirements of HCQIA and therefore were not entitled to immunity.

In summary, Colorado physicians who participate in peer review must now realize that good faith alone may no longer be sufficient to guarantee immunity from liability. The best protection from liability, in addition to good faith, is to carefully comply with the procedural requirements of the peer review statutes and the hospital's bylaws. In this regard, peer reviewers may wish to secure the assistance of legal counsel early in the peer review process to help ensure compliance with all required procedures. It is possible that the Nicholas decision will be appealed to the Colorado Supreme Court, and if the Supreme Court accepts review, it may well choose to restrict the opinion's scope. Until then, the Nicholas case is the law.

1 No. 98CA1407, December 9, 1999.
2 101 F.3d 1324 (10th Cir. 1996).

CMS Med Fax

Did you know there is more than one kind of Medicare audit?

In fact there are four currently conducted by the Medicare on a regular basis. They are the pre-payment review, the Focused Medical Review, the Comprehensive Medical Review and the audit of Electronic Claims Submission.

- The *pre-payment review* has been mandated by HCFA to see how well physicians are doing on their E & M documentation. HCFA rotates the E & M codes to be reviewed and the Carrier must randomly select 4% of the claims submitted with the "chosen" codes for review prior to payment. Based on review of the documentation provided, the claim will either be paid as billed, down-coded or denied. These pre-payment reviews are happening nationally and are part of HCFA's initiative to *pay claims right the first time.*
- The *Focused Medical Review (FMR)* is just that, the Carrier is looking at specific services post-payment. Each year HCFA supplies the Carrier with data that shows those services, supplies and procedures that are above the national norm in Colorado. From this information the Carrier then looks for those doctors in Colorado who are providing the services in question and *focuses* on those at the high end. If you are part of a Focused Medical Review, you will receive a letter from the Carrier requesting a limited number of records (usually not more than eight) for one particular date of service. You will receive notification from the Carrier if you pass or fail the audit. If you do not pass the FMR you may be subjected to additional audits, including a Comprehensive Medical Review.
- The *Comprehensive Medical Review (CMR)* is also a post-payment audit but it is more serious. It entails a thorough analysis of a cross-section of services on at least fifteen claims. A doctor is generally chosen for a CMR because his/her pattern of practice is significantly different from others in the same specialty and location. The outcome of the audit will vary depending on what problems are identified. There will usually be some type of educational contact made by the Carrier. There could be a request for repayment of claims found to be overpaid. You could be placed on additional periodic post-payment reviews, or if the problem is serious, you could be placed on pre-payment review.
- The *Electronic Claims Submission* audit is done to verify that the claims transmitted by your office actually reflect the services provided. For in office services you will also have to prove that the patient showed up. The records review that is done to prove the electronic claims were valid is not as in depth; for example, they are not scrutinizing the records to be sure that the documentation supports the level of service billed.
- *What should you do?* Don't panic - but do be responsive. Be sure that the requested documentation is returned within the time limit specified in the letter. If there is going to be a problem responding in time, contact the person named in the letter. Be sure to provide all of the documentation that supports the service billed. If you had a consultant help you with some of these same billing issues in the past contact him/her. They may be able to assist you in identifying what information in the chart will justify the service. Keep copies of everything you send to the Carrier. If you do receive a request for money back check your Remittance Advice to be sure that the service was actually paid in the first place. If there are questions, contact the Carrier.

Because of the random nature of the pre-payment audits of E & M documentation, it is entirely possible that you could get "caught" in more than one type of audit. The biggest threat these audits pose for *most* physicians is not the possibility of fraud conviction it is the real possibility that the Carrier will ask for money back. If you would like more information, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653, ext. 2428.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

26th Annual Vail OB/GYN Conference
February 20 - 25, 2000
Vail, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

Ski & CME Midwinter Conference
February 27 - March 3, 2000
Keystone Lodge & Resort
Keystone, Colorado
Contact: Brooke Chynoweth, (303) 322-1956 or *info@Colorado DO.org*

The 7th Annual Echocardiographic Workshop on 2-D and Doppler Echocardiography at Vail
February 28 - March 2, 2000
Vail, Colorado
Contact: Registration Secretary, Extramural Programs (800) 253-4636 ext 695

CRASH 2000 - Colorado Review of Anesthesia
March 4-10, 2000
Marriott's Mountain Resort
Vail, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

Pulmonary & Critical Care Medicine Conference
March 15 -18, 2000
Big Sky Ski Resort
Big Sky, Montana
Contact: (406) 442-6556 or *alamty@aol.com*

Clinical Updates in Correctional Health Care
March 19-21, 2000
New Orleans, LA
Contact: (773) 880-1460 or www.ncchc.org

Recapturing the Soul of Medicine
March 29 - April 2, 2000
Seabrook Island, *The Conference Resort*
South Carolina (near Charleston)
Contact: (800) 621-8335

Second Annual Update in Geriatric Psychiatry & Geriatric Medicine
March 30 - April 2, 2000
Keystone Resort
Keystone, Colorado
Contact: (303) 315-9653 or *Linda.Hay@UCHSC.edu*

Endourology 2000
March 31, 2000
University of Colorado Health Sciences Center
Denver, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

4th Annual Ophthalmology Symposium
March 31 - April 1, 2000
Denver, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

40th Annual Conference on Legal Medicine
March 31 - April 1, 2000
San Diego Hilton Beach & Tennis Resort
San Diego, California
Contact: ACLM (800) 433-9137 or *info@aclm.org*

Health Promotin Excellence in the New Century: Ascending New Hights
May 16 - 19, 2000
Adam's Mark Hotel
Denver, Colorado
Contact: Kate Demas (202) 408-9804 or *Kdemas@sophe.org*

4th Annual Symposium, Contemporary Approches to the Management of the Risk Factors for Cardiovascular Disease
May 19, 2000
Denver, Colorado
Contact (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

5th International Conference on Pediatric Trauma
June 17-20, 2000
Vail-Beaver Creek, Colorado
Contact: (719) 365-5888 or *www.pedtraumaconf.org*

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact (800) 332-2264 x 260

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Can it be that we are already in February, 2000 without a clear idea of how medicine is to be practiced in this new year/new century? Struggle we must to deal with 2000 and what it holds for medicine. There will be surprises, yes. But many things which will occur this year actually were foreseen years ago.

One of those events may well be the total, complete, absolute manner in which physicians practice medicine. And a very good example of this phenomenon is the news story in December of the Washington state physician who is now offering a discount for cash payment by patients.

Quoting from the Seattle Times story, the doctor decided that he could stave off bankruptcy if the patients were to pay cash, and everybody would be happier. He would not have to pay administrative overhead while charging a reasonable, reduced fee, and the patients (even ones without insurance) gain access to health care. The doctor says 30 to 40% of his patients are already COD.

Of course, there are critics to this man's new "cash-only" system; a good example of this is 'What happens if a patient gets really sick?' If there is no catastrophic health insurance, the sick person will have to come up with the cash, or go on the public dole.

And what about the patient with serious problems, such as cancer or a brain tumor? The doctor noted that only 3 to 5% of patients need to spend over $2,000 per year on health care. That doesn't provide any answer to that patient who does come up with a life-threatening catastrophe. Obviously, this system is not the best for everyone, even though the doctor says it saved his practice from bankruptcy and he is still able to care for patients at a reasonable rate. He hopes to sever ties with the remaining insurers soon.

There's one other factor in the Washington doctor's scheme: each participant in his program pays a $20 annual fee ($35 for families), and the physicians in the system promise to charge their "best price" to the cash-paying patients. And here's a hooker: for a $35 fee, the cash patient is linked to the doctor's numerous web sites where they can buy "vitamins, minerals, herbal products and other nutritional supplements and health products." The 'Internet commerce' aspect of the system is probably what has saved the doctor's fiscal skin.

So.... is this the way we want medicine to go in 2000? Is this what physicians are working to accomplish? In many cases, this would be a welcome layer of effort to their practice, which is about to go down the tubes anyhow. But in most cases, physicians do not and will not agree to practicing medicine in this manner. It is neither good for the patient nor the provider.

In 1962, in his response to the speech by President John F. Kennedy about Medicare, AMA President Edward Annis, MD, said the advent of Medicare would, without question, forever change the delivery of health care and the practice of medicine. That's been happening ever since, but the year 2000 may be pivotal because, quite likely judging by many reports, Medicare may be on the brink of collapse. More and more third-party payers are backing off their deal to provide capitated care for the elderly Medicare clients. In the meantime, doctors are going broke because they can't get paid for the Medicare patients they are caring for.

"So.... is this the way we want medicine to go in 2000?"

Former CMS President Robert Sawyer wasn't kidding back in 1979 when, after leaving office, he observed pretty soon we'll see surgeons advertising discount price on appendectomies, if you come in today. He may not have been far wrong.

Already, we've seen a lot of hoopla over the practice of medicine on the Internet, selling prescription drugs, offering alternative treatments and who knows what else.

Oh, there have been wholesale changes in the provision of healthcare in just the past few years, but 2000 is going to be a very pivotal year as these emerging factors work their way in and grossly impact health care and medical practice.

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COlorado Medical Political Action Committee

P.O. Box 17550
Denver, Colorado 80217-0550

It's the "Capitol Season" when your voice needs to be heard at the State Capitol

You can become personally involved in the future of health care in Colorado **without playing politics.** You'll be heard **every day** of the 2000 legislative session. Join COMPAC, then rest assured your voice in organized medicine will continue to be heard at the state legislature.

For information call
(303) 779-5455, extension 2427
or 1 (800) 654-5653.

Congratulations. . .

to State Representative Brad Young of Lamar, Colorado.



Rep. Bradley J. Young (R)
Dist. 63, Colo. Gen. Assy.

Thanks to his efforts and devotion to the cause of rural Coloradans, the legislature has before it a bill which will extend a state income tax credit to health care professionals who practice in professional shortage areas.

The bill **(HB 1063)** is designed to help attract more health care professionals to the rural areas of the state where physicians, physician assistants and nurses are sorely needed.

As the proposal states, that in order for all geographic areas of Colorado to have the opportunity for economic development, it is vital that excellent health care be available throughout the state.

The bill states that "It is therefore the intent of the General Assembly to provide a tax credit for the purpose of payment of student loans as a financial incentive to encourage health care professionals to locate in medically underserved areas of the State of Colorado." Underserved areas are those areas that are designated a "Health Care Professional Shortage Area."

Representative Young, an agricultural engineer, is serving his third term in the House, representing Arapahoe, Cheyenne, Elbert, Kiowa, Kit Carson, Lincoln, Prowers and Yuma counties.

CPHP

Colorado Physician Health Program

Dedicated to Physician Peer Health Assistance

899 Logan Street
Suite 410
Denver, CO 80203
303-860-0122
1-800-927-0122

CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health Program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

The Lobby



Christopher J. Unrein, DO
Chairman
CMS Council on Legislation

The 2000 Colorado Legislative Session is off to a running start. The CMS Department of Government Relations is working diligently on the hot topics of 2000. While other reports might have you believe that transportation, growth and education are the hot agenda items, CMS believes that the following list makes it clear that health care continues to be an important issue for Colorado Legislators.

The laundry list of bills follows:

- Use of the Tobacco Settlement Funds (Several bills are anticipated, specifying how the money will be spent.)
- SB 34, Disease of Obesity Prevention (Authorizes the Dept. of Health Care Policy to study obesity)
- SB 48, Insurance Coverage for Mammography Screening for Men (Mandates that insurance plans cover mammography screening for men)
- SB 54, Creation of an Organ and Tissue Donor Registry (Creates a statewide registry of organ and tissue donors)
- SB 88, Colorado Medicaid Program
- SB 95, Access to Eye Care Coverage (Allows for direct access to optometrists and opthalmologists without a referral)
- SB 116, Copies of Medical Records (Specifies a maximum fee that a provider/facility may charge for copies of records
- HB 1023, Immunization Registry (Requires the Dept. of Public Health to study the cost of implementing and maintaining an electronic tracking system of children's immunizations)
- HB 1036, Coroners Access to Medical Information (Allows coroners access to mental health records when investigating a death)
- HB 1037, Catastrophic Health Insurance Coverage (Changes minimum and maximum deductibles for individual and family coverage)
- HB 1038, Increase Public Membership on BME (Adds two members of the public to the Board of Medical Examiners)
- HB 1058, Failure to Truthfully Respond to BME Complaints (Classifies that failure to "truthfully respond" in a manner that fully discloses all information to a complaint as "unprofessional conduct")
- HB 1063, Tax Credit for Providers Practicing in Health Care Shortage Area (Provides tax credits for physicians, PA's, and NP's who practice in a health care shortage area)
- HB 1075, Physician Collaboration and Nurse Midwives (Clarifies contradicting statutes and enables certified nurse midwives to work within collaborative agreements)
- HB 1076 Prenatal Care for Undocumented Women (Directs the state to provide prenatal care for undocumented women through contracts with managed care companies)
- HB 1078, Penalties for False Medicaid Claims
- HB 1104, Tax Credits for Health Care (Allows Colorado residents to claim tax credits for amounts paid for health benefit plans)
- HB 1131, Mandatory Use of Seat Belts (Makes it a primary offense to operate a motor vehicle without all front seat passengers wearing safety belts)
- HB 1132, Lower Blood Alcohol to 0.08 for DUI (Lowers the blood alcohol level from 0.10 to 0.08 for DUIs)
- HB 1156, Prohibit use of Cell Phones while driving (Exempts hands free units)

For more information on the bills CMS is following go to the CMS Home page www.cms.org, and click on the Legislative Digest button. The State of Colorado has its own web site and offers daily calendars of the legislature, bills, status of bills, and directory of legislators. Go to www.state.co.us/gov_dir/stateleg.html.

As you can see the list is long and growing. Your input is vital to the legislative process. Last year when CMS lobbied HB 1250, Timely Payment of Insurance Claims, legislators commented that they heard from physicians. As the session continues, bills will flow through the process and it is imperative that you, as a physician, stay involved in the process, call your legislators, write your legislators, testify before a committee, and respond to CMS alerts.

Is your practice ready to "Go On Line"?

If you have a practice website, it can be linked to the Colorado Medical Society web page. AND. . . we'll do it for you! No muss. No Fuss. No cost.

If you're thinking about ways to market your practice in these days of high-tech anything and everything, then the Internet is probably where your practice belongs. If you currently have a web page for your practice, then this is a way to make you and your practice more accessible, more recognizable and certainly more available.

Here's all you do:
Complete the little form on this page, send it in to CMS, and we'll take care of the rest, at no charge to our members.

Here's how it works:
We go to the CMS "Member Locator" on the web, select your name, and add the link right there, under your name, to your web page. This is a new world of marketing and communications, and you should be at the forefront.

We have been making this member service available for the past five months, and now that more and more practices are becoming very Internet-literate, it's time for you and your physician associates to be out front with your consumer-oriented medical care information.

Just what's the value of your being on the world-wide internet? Are there patients out there in cyberspace that might come to you? We don't actually know the answer, but it IS rather doubtful. However, there's a whole new world of information of all sorts that can be gathered in "bits and pieces."

The Internet is all about exchange of informtion. Your practice goes "on line" and another physician sees it and suddenly knows a great deal about your practice. He/she has similar interests, problems, solutions and cures. You get together and suddenly you've found a new approach to something in your own practice.

People move to Colorado at an excessive rate, and when they get here they don't have a personal doctor. What better way to find one than through your own practice web page, where you can tell them about your medical offices, clinic, etc. The inflow of new residents is expected to continue well into the new millennium, so you should be at the forefront of information dissemination as well as gathering. The Internet is the obvious vehicle for today.
CMS will help you use it to your best advantage. Complete the form below and send it back to CMS. We'll do the rest to launch your medical practice into the new age.

Complete this form and mail to: **CMS Communications & Member Services**
P. O. Box 17550
Denver, CO 80217-0550

Print or Type the following information

Please create a URL Link in your member database to my medical practice web page;

My Name _____

Mailing Address _____ **City** _____ **State** _____

URL http//www. _____

E-mail address _____ **Telephone ( )** _____

Anita Albrecht
Director
Colorado Medical Society Foundation

Thank you for your generosity

"On behalf of our physicians, staff, and board members, I want to extend to you and the CMS Foundation our heartfelt gratitude for your consideration in this matter. As a small rural hospital in a frontier area of Colorado, our resources are limited."

"Assistance such as yours truly contributes to our ability to continue offering quality health care to the citizens of our county. Again, we sincerely thank the CMS Foundation for your generosity in this matter."

Marvin Bishop, CEO
Weisbrod Memorial Co. Hospital
Eads, Colorado

"On behalf of the Board of Directors of the West Custer County Hospital District, Dr. Bliss, and the entire staff of the Custer County Medical Clinic, I would like to thank you for your generous donation. We are badly in need of this equipment and will utilize your funds accordingly."

Toloa Pearl, Administrator
West Custer County Hospital

"On behalf of the Valley-Wide Health Services, Inc, I would like to thank you for the funding we received through the Colorado Rural Outreach Program. Through your donation, we will be able to improve the availability and quality of medical equipment in our rural clinic sites."

Konnie Martin, Vice President
Valley-Wide Health Services, Inc.
Alamosa, Colorado

Map	Community	Organization/Grant Awarded
A	Haxtun	**Dr. Jose Hinojosa** Loan Repayment
B	Eads	**Weisbrod Memorial Hospital** Helped purchase cardiac telemetry unit
C	Alamosa	**San Luis Valley Area Health Education Center** Enabled two high school students to participate in a health careers institute
D	Delta	**Dr. Kae Loverink** Loan Repayment
E	Del Norte	**Rio Grande Hospital** General recruitment support
F	Alamosa	**Valley-Wide Health Services** Helped purchase equipment: crash carts and defibrillators
G	Cheyenne Wells	**Keefe Memorial Hospital** Helped purchase a portable X-ray machine
H	Westcliffe	**Custer County Medical Clinic** Helped purchase basic medical equipment: pulse oximeter, hyfercator, and equipment sterilizer
I	Springfield	**Southeast Colorado Hospital** General recruitment support
J	Lamar	**High Plains Community Center** Facility enhancement



Leaving a legacy of generosity through programs that improve access to health care for all Coloradans.

COLORADO
Coalition for the Medically Underserved

Registration

There is **no charge** for this dynamic conference!

Name _____

Organization _____

Phone _____

FOURTH ANNUAL CARING FOR COLORADO'S MEDICALLY UNDERSERVED CONFERENCE

Friday, March 3, 2000
8:00 a.m. - 4:30 p.m.

Radisson Hotel Denver Stapleton Plaza
3333 Quebec St., Denver, CO

Keynote speakers include:
Henry Simmons, MD
President, National Coalition on Health Care

Marilyn Gaston, MD
Assistant Surgeon General; Director, Bureau of Primary Care

The purpose of this regional conference is to focus on health care, health insurance coverage, access to health care and the needs of the medically underserved. This year's program will be better than ever. We've used the comments and evaluations from past conferences to improve the program. As usual there will be lots of new information and many opportunities to learn, network and recharge your batteries!

Similar to years past, an awards ceremony honoring three people that provide outstanding service for the medically underserved will be held. Also returning again will be the ever-popular poster contest for local programs serving the medically underserved.

There is **no charge** for this one-day conference.

To register: Complete this form and send it back to us at **(fax) 303-771-8657** or mail to **Coalition for the Medically Underserved, PO Box 17550, Denver, CO 80217-0550** attn.: Anita Wesley.

Hotel arrangements: A special room rate of $79.00 is available to conference participants (Please call the Radisson at 303-321-3500 and mention the Coalition for the Medically Underserved).

For more information contact **Anita Wesley** at (303) 930-0426.

COLORADO
Coalition for the Medically Underserved

FOURTH ANNUAL CARING FOR COLORADO'S MEDICALLY UNDERSERVED CONFERENCE

Radisson Hotel Denver Stapleton Plaza
3333 Quebec St., Denver, CO • 303-321-3500

Program for Friday, March 3rd

8:00-8:30	Registration/Continental breakfast
8:30-8:35	Introductions and welcome *Gary D. VanderArk, MD*
8:35-9:25	**Guiding principles for successful reform** *Henry Simmons, MD, President, National Coalition on Health Care*
9:25-9:45	**Gaining momentum: Progress report on CMU activities** *Gary D. VanderArk, MD*
9:45-10:05	Networking break in poster area
10:05-11:05	Break out sessions a) **Coverage and access for all: What's the bottom line? An analysis of various reform efforts and approaches** *Barbara Yondorf* b) **A new moral vision for health care** *Former Gov. Richard Lamm and Abe Kauvar, MD* c) **Mobilizing your community: A grassroots session on increasing legislative advocacy, maximizing community resources, communicating with the media and raising awareness about the underserved** *Jennifer Miles, Suzanne Hamilton, Stephanie Denning* d) **In the trenches: Community approaches to addressing the needs of the underserved. Learning from the experiences of four Colorado communities** *Carol O'Dowd, Adams County; Sally Kane, Delta County; Byron Geer, Pueblo County; Sue Birch, Routt County (invited); Elena Thomas, Moderator*
11:05-11:45	Lunch
11:45-12:00	**Awards session** *Gary VanderArk, MD, Presentor*
12:00-12:30	**Luncheon speaker** *The Honorable Bill Owens (invited)*
12:30-1:15	**Evaluating current statistics on the medically underserved and the effect of reforms in Medicaid, CICP and CHP+** Panelists: • *Bill Lindsay, Benefit Management & Design* • *Pete Leibig, Clinica Campesina* • *William Kirven III, Division of Insurance* • *Richard Allen, Department of Health Care Policy & Financing* *Moderated by Peg O'Keefe*
1:15-2:15	Break out sessions (same as above)
2:15-2:30	Break—(poster session area)
2:30-3:30	**Heard on the hill: Legislative update** Update on activities at local, state and federal levels Potential panelists include: *Congresswoman Diana DeGette (invited) , Senator Mary Ellen Epps (invited); Representative Marcy Morrison (invited); Ruth Aponte; Suzanne Hamilton; Jennifer Miles*
3:30-3:35	**Announcement of winning poster**
3:35-4:20	**Health care revolution from the community up—100% Access, 0% Disparities** *Marilyn Gaston, MD, Assistant Surgeon General, Director, Bureau of Primary Care*
4:20-4:30	Closing remarks *Gary D. VanderArk, MD*

To all members of Colorado Medical Society:

In January you were sent the letter which appears below, with your practice and personal information according to our current records. This letter is extremely important. It should be read, the information corrected where necessary, questions answered and sent back to Colorado Medical Society as soon as possible. The letter indicates how you wish to be listed in the CMS ***2000 - 2001 Resource Book for Medical Offices,*** CMS membership listings.

Please note that there is room for only one (primary) practice listing. You should select the practice site which is most convenient for you to receive referrals, mail, inquiries and peer-to-peer communications.

Thank you for completing this form and returning it. If CMS does not receive the completed form, your listing in the ***Resource Book*** will remain the same as in the 1999-2000 edition (unless otherwise revised).

COLORADO MEDICAL SOCIETY

"Advocating excellence in the profession of medicine"

January 19, 2000

Dear Dr.

We are updating our files prior to the publication of the *2000 Medical Office Resource Book* (the "Directory"). Please make any necessary corrections to the information listed below. To insure the accuracy of your listing in the Directory, it is imperative that you **sign and return this letter**, whether or not corrections are made, **by March 1, 2000**. Thank you.

PLEASE PRINT OR TYPE

DIRECTORY INFORMATION 11468

(REQUIRED FOR AN ACCURATE LISTING)

Primary Office Address & Telephone

Home Address & Telephone

Have you retired from medical practice?..... ❑ Yes ❑ No

Please indicate any foreign languages that you speak..... Spanish

Please indicate your medical specialties.....
See the reverse side of this page for details. Family Practice

If you would like us to include your internet e-mail address with your listing, please provide it below:

My internet e-mail address is **(PLEASE PRINT LEGIBLY)**.....

Physician's Signature _____ **Date** _____

7800 E. Dorado Pl., Greenwood Village, CO 80111 • (303) 779-5455 or (800) 634-5653 • FAX (303)771-8657 • PO Box 17550, Denver, CO 80217-0550

STATE OF COLORADO

DIVISION OF INSURANCE
William J. Kirven, III
Commissioner of Insurance
1560 Broadway, Suite 850
Denver, CO 80202



Bill Owens
Governor

December 28, 1999

THE 1999 STATEMENT OF ACTUARIAL OPINION

To All Colorado Domestic Insurers:

We are writing to advise you of the Colorado Division of Insurance's expectations for the 1999 Statement of Actuarial Opinion for all Colorado domestic health insurers or HMO's who have entered into any kind of risk-sharing, usually contractual, arrangements with provider groups providing medical services to enrollees. Examples of this type of arrangement are:

1. Capitation contracts with a separate IPA corporation, multi-specialty medical group or hospital.
2. Capitation contracts with specialty provider entities such as a drug company or mental health services organization.
3. Capitation contracts with primary care physicians plus financial incentives/risks that are a function of a primary care physician's management of inpatient hospital and /or specialty physician costs.
4. A withhold of a portion of physician fees.
5. Any other similar arrangement.

The Actuarial Standards Board adopted Actuarial Standard of Practice No. 16, "*Actuarial Practice Concerning Health Maintenance Organizations an other Managed-Care Health Plans,*" in July 1990. Under this Standard, the actuary is expected to "determine the types and scope of these arrangements and their impact on health claim liabilities and rates." An example of the review expected from the opining actuary can be found in Part 5.1.4 of this Standard, which states that:

> *"The actuary should include in all MCHP claim liability and rate opinions a statement disclosing the actuary's knowledge of all capitated risk contracts between the MCHP and provider entities. This statement should indicate whether the actuary has evaluated the financial position of the provider entities. The actuary should make appropriate inquiries of responsible persons regarding the financial condition of provider entities that assume financial risk through a capitation mechanism.*
>
> *The actuary's statement should disclose knowledge of, and make appropriate provisions for, any financially insolvent provider entity that may have a material effect on the MCHP's rates, reserves, or financial condition.*
>
> *Some IPAs enter into capitation contracts with multiple MCHPs. In these cases, rarely will the actuary have access to information on the financial position of the IPA except with respect to the specific MCHP the actuary serves. The actuary should disclose in reserve opinions the existence of any IPAs with multiple capitation contracts and indicate whether the financial position of the IPA and resulting impact, if any, on MCHP liabilities have been evaluated."*

In addition, §10-16-705 (5)(a), CRS, requires a carrier, in certain circumstances, to remain responsible for the payment of providers, irrespective of whether or not the carrier has already paid an intermediary for the services provided. The Colorado Division of Insurance therefore expects the opining actuary to comply fully with all the requirements of Actuarial Standard of Practice No. 16, and to consider the requirements of §10-16-705 (5)(a) in any expression of opinion regarding a carrier's reserves or financial position.

To accomplish this, the Colorado Division of Insurance expects the opining actuary to review all material contractual arrangement, and comment in the required annual actuarial opinion on the ability of the underlying entity to adhere to the financial arrangements and other terms of the contracts. It is not sufficient for the opining actuary to state that the financial position of the provider entity has not been reviewed. Opinions without such a review will be returned to the issuing company as incomplete, and a revised actuarial opinion will be required.

Should you have any questions concerning this letter, please contact Victoria Lusk, Chief Actuary of the Colorado Division of Insurance, at (303) 894-7499, ext. 316.

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Attention - Colorado Medical Society Members

One certificate per Alamo rental and void once redeemed. • Original certificate must be presented at counter upon arrival. • Free day is pro-rated against basic rate of entire rental period, which does not include taxes (including VLF taxes up to US$1.89 per day in California and GST), governmentally-authorized or imposed surcharges, license recoupment fees or other optional items. • Offer is subject to standard rental conditions. • Subject to availability and good only at participating Alamo locations. • Blackout dates may apply. • Not valid with any other discount or promotional rate.

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Bill Pierson, Director
Communications & Member Services
Colorado Medical Society

9Health Fair

*Endorsed by the Colorado Medical Society**

The 9Health Fair is, indeed, a service to the members of the Colorado Medical Society. "How can that be"? you ask yourself. Colorado Medical Society does not directly participate in any 9Health Fair function, nor does it support the activity, financially or in kind.

The physician members of CMS are invited each year, or have been for the past 19 years, to participate in the health fairs at any of the various sites across the entire state.

- Each year, the health fairs are more and more shaped by physicians who volunteer their time and efforts as members of the 9Health Fair Board of Advisors.
- Each year, 9Health Fair sees more people at all of its sites, getting more individuals involved in a self-regulated health care system.
- Each year, numerous physicians make a very positive impact on the population at large by providing their medical skills at 9Health Fair sites. The impact is not only on the people examined, but on the hundreds of other people as well who volunteer their services to 9Health Fair. They know and appreciate the value of volunteerism and feel an unusual gratification in working alongside volunteer doctors.
- Each year, physicians are feeling they are being pushed farther and farther away from patients because of the many layers of desktop diagnostics and bureaucratization of medical practice. Many are ready to give up medicine because of these incursions on their profession. They long for the recognition and sincere friendship of people outside the medical profession (the patients).

Why is it, then, that this service to the CMS members goes so unnoticed by the members? Why don't we see more CMS members taking advantage of the opportunities offered doctors to volunteer and be among the ranks of caring volunteers at 9Health Fair sites? They need doctors to help, more than anything else. In 1979, Colorado Medical Society advocated for the physician, holding the 9Health Fair founders and supporters at arms length, for fear of development of a patient-physician relationship and practice liability at these examination sites.

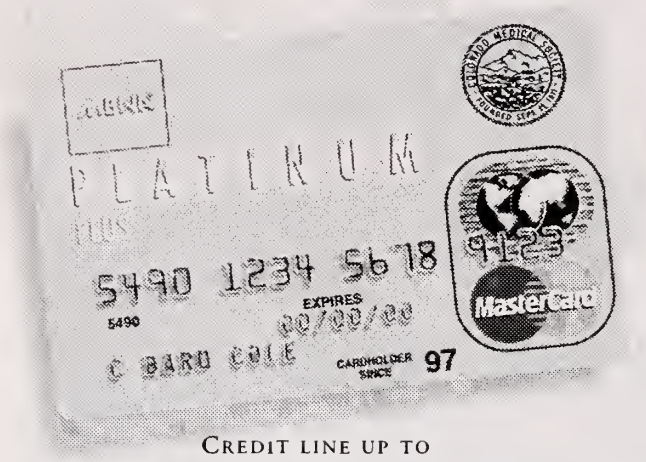
In 1980, CMS executives said the only way the organization would participate would be if CMS member physicians were allowed to shape the Fair, directing it away from physical examinations to health education, for those who did not have a personal physician, could not afford one, and were generally not seeing to their own care. Over the ensuing 19 years, physicians have been on every 9Health Fair Advisory Board and have participated in shaping the event. Per our request, for each of the 19 years, CMS has received a full report on every examination and person-contact made at the Fair sites. Each unusual or extraordinary physicial circumstance or condition discovered through examination and lab work was reported, and that person was advised to see a medical doctor of his/her choice. For the past ten years, Colorado Medical Society House of Delegates has approved CMS's endorsement of the 9Health Fair. As a result, each piece of printed material from the 9Health Fair carries the CMS endorsement message*. All the public who see the KUSA-TV, Channel 9 promotions of the health fairs see that CMS endorses this Fair.

The 9Health Fair is one of the best and most gratifying public forums there is for physicians, yet we haven't enough doctors using it to fill the need.

This will be the 21st 9Health Fair, lasting one week at over 140 sites around the state (there's one near you) **April 1 through April 9, 2000.**

You still have time to sign up to participate in this, one of the best CMS member services available. Try it. I believe you'll like it. If you don't or are unhappy with the results, let me know and we'll see that the problem is solved (within reason) to your satisfaction.

THE NEW STANDARD ISN'T GOLD.



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$100,000

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Please return form to: MBNA® *Platinum Plus* New Account Acceptance Center, P.O. Box 15464, Wilmington, DE 19850-5464.

Print your name as you would like it to appear on card. *Please print clearly in black or blue ink.*

GV4T
JM-94
V8

Name _____ Social Security # _____ Birth date _____ Mother's maiden name _____

Address _____ City _____ State _____ ZIP _____

Monthly housing payments $ _____ Are you: ☐ Homeowner ☐ Renter ☐ Other

Home phone (____)_____ Business phone (____)_____

Employer _____ Position _____ Years there _____ Source of other income‡ _____

Please send an additional card at no extra cost for:
_____ Relationship: _____

Your annual salary $, .

Other income‡ +$, .

Total household income $, .

‡Alimony, child support, or separate maintenance inc need not be revealed if you do not wish it considered basis for repayment.

X _____ Date / /

MY SIGNATURE MEANS THAT I AGREE TO THE CONDITIONS APPEARING ON THIS FORM.

Please complete only if you have moved or changed employers in the last three years.

Previous Address _____ City _____ State _____ ZIP _____

Previous school or employer _____ Years there _____

Annual fee	None.
†Annual Percentage Rate (APR)	14.99% fixed for purchases.
Grace period for repayment of balance for purchases	At least 25 days, if each month, we receive payment in full of your New Balance Total by the Payment Due Date.
Method of computing the balance for purchases	Average Daily Balance (including new transactions).
Transaction fees for cash advances and fees for paying late or exceeding the credit limit	Transaction fee for Bank and ATM cash advances: 2% of each cash advance (minimum $2). Transaction fee for credit card cash advance checks: 1% of each cash advance (minimum $2, maximum $10). Late-payment fee: $25. Over-the-credit-limit fee: $25.
Transaction fee for purchases	Transaction fee for the purchase of wire transfers, money orders, bets, lottery tickets, and casino gaming chips: 2% of each such purchase (minimum $2).

The information in this application is accurate as of 12/97. The information may have changed after that date. For more current information, please call MBNA at 1-800-523-7666. TTY users, please call 1-800-833-6262.

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†–MORE APR INFORMATION–

The current promotional Annual Percentage Rate (APR) offer for cash advance checks and balance transfers made with either account is 5.9% through your first five statement closin dates, commencing the month after your account is opened. When your minimum month payment is not received by the close of the first complete billing cycle following its Payme Due Date, or when the promotional offer expires, whichever occurs first, the APR that will applied to both new and outstanding cash advance balances (consisting of cash advance check and balance transfer transactions) will be 14.99%. MBNA may allocate your monthly payments to your promotional APR balance(s) before your nonpromotional APR balance(s

–CONDITIONS–

I have read this application and everything I have stated in it is true. I authorize MBNA Am Bank, N.A. (MBNA) to check my credit, employment history, or any other information and to report to others such information and credit experience with me. I understand that the accep tance or use of any card issued will be subject to the terms of this application and the Credit C Agreement that will be sent with the card, and I agree to be responsible for all charges incurr according to such terms.

Unless I write to MBNA at PO Box 15342, Wilmington, DE 19850, I agree that MBNA and its affiliates may share information about me or my account for marketing and administrativ purposes. I am at least 18 years of age. I consent to and authorize MBNA and its affiliates t monitor and/or record my telephone conversations with any of their representatives to be ensure quality service. **I understand that if this credit card application is approved for an account with a credit line of less than $5,000, I will receive a Preferred Card.**

*Certain restrictions apply to this benefit and others described in the materials sent soon aft your account is opened. Preferred Card Customer benefits differ: Year-End Summary of Charges and Purchase Protection are not available; maximum Common Carrier Travel Accid Insurance coverage is up to $300,000; and there are additional costs for Registry benefits. MBI a federally registered service mark of MBNA America Bank, N.A. MasterCard is a federally registered service mark of MasterCard International Inc., used pursuant to license.

MBNA America Bank, N.A., is the exclusive issuer and administrator of the *Platinum Plus* credit card program.

8120000906

In 1999, Colorado Medical Society continued its unprecedented growth. At a time when other professional organizations were decreasing in size, CMS continued its upward trend by a small percentage. As the number of total members grew, percentages of membership types were changing; i.e., Active Emeritus and Dues Exempt members grew by 1% of total membership, while Resident and Student membership percentage dropped by a like amount. We won't attempt to analyze this small but measurable trend, except to say that, like any 129 year old professional organization, CMS is an aging group. There are, however, strong member advocacy and worthwhile member service programs to continue to attract new physicians to the CMS ranks.

Copic Professional Liability Insurance continues to be a strong attraction, offering a worthwhile premium discount to CMS members.

Legislative issues and the highly effective CMS Legislative Affairs division are meaningful; CMS has a notable lobbying staff and major presence at the state capitol.

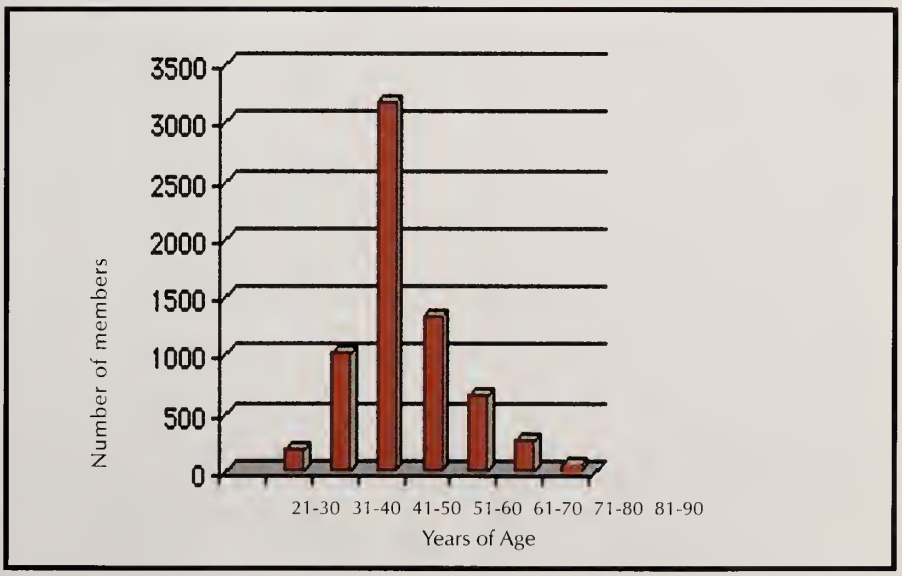
Colorado Medical Society also offers invaluable aid in understanding and staying abreast of practice procedure coding, helping physicians be more effective in billing practices. CMS has some of the brightest and best qualified staff members in handling physician inquiries and help requests in this area.

In close harmony with this is the natioanlly noted ***"Hassle Factor Project,"*** which has been one of the leading advocates for timely payment by third-party payers. Thanks to this effort, the Colorado State Legislature last year passed "Timely Payment" legisltion which will be a great service to all health care providers.

Resident and Student programs have brought valuable resources to the resident and student members of CMS. The ongoing lecture series at the University of Colorado School of Medicine continues to attract medical students to CMS membership, where they have an active and sought-after voice in the Society. Students and Residents alike have representatives on the CMS Board of Directors and members in the House of Delegates.



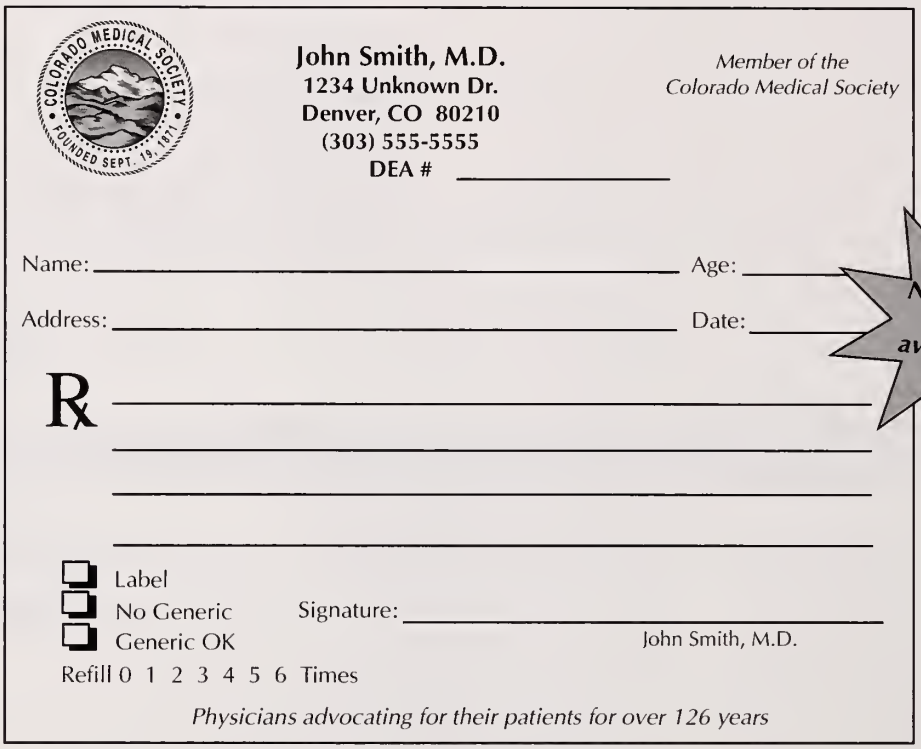
CMS Membership Snapshot



There are 4,405 male (80.5%) and 1,108 female members. These figures are rapidly changing as of this turn of the century. 56% of the total membership are between 41 and 50 years of age. The last turn of century saw only 301 total members (all male), the majority, as near as we can tell, 41 to 50 years old.

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Rich Kessel, PhD,
Angela Sauaia, MD, PhD, and
W. William Schluter, MD, MSPH

Health Care Financing Administration Focuses on Outpatient Care

Articles in recent issues of ***Colorado Medicine*** have highlighted some of the Colorado Foundation for Medical Care's (CFMC's) activities in response to Health Care Financing Administration (HCFA) defined national priority topic areas. Perhaps of greater interest to individual practitioners is HCFA's new focus on outpatient quality improvement. HCFA is using the same data collection and analysis methodology described in the December 1999 issue to evaluate outpatient care in three national topic areas; pneumonia prevention (influenza/pneumococcal vaccination), diabetes treatment and breast cancer screening. As with the inpatient topic areas, it is CFMC's mission to assist Colorado practitioners with their quality improvement efforts.

The quality indicators for the three outpatient topic areas and the baseline rates (using 1998 data) for Colorado and 19 other states are shown in ***Table 1.*** While Colorado continues to be strong in the area of vaccinations, there is room for improvement in every indicator.

CFMC has extra Valentine's Day cards available to physicians to send to their female Medicare patients reminding them of the benefits of screening mammograms. We are excited about this project because we recently made free postage-paid post cards available to physicians to remind their Medicare patients of the need for immunization against influenza and pneumococcus. While only 10% of the state's physicians chose to participate in the immunization campaign, initial follow-up indicates that these practices experienced a surge in vaccination requests. CFMC continues to work with other members of the Colorado Influenza and Pneumococcal Alert Coalition (CIPAC) to further increase vaccination rates.

Physician-patient cooperation is also the basis of a diabetes tool kit which will be sent to physicians, pharmacists and diabetes educators throughout Colorado. Contents of the kit have been endorsed by many prominent health services organizations. Along with reminder materials, the kits include brochures with tear-off wallet cards that allow patients to take charge of their diabetes treatment. These cards have been shown to be highly effective when endorsed and used by the patient's physician. Included in the physician targeted kits is a diabetes flow sheet. This tool was developed by the Colorado Clinical Guidelines Collaborative and has already been shown to have a major impact on improving diabetes care locally. CFMC is also available to assist physicians pursuing American Diabetes Association accreditation, which requires a diabetes quality improvement project.

In addition to projects addressing the national priorities, CFMC is working on three local initiatives:

- to increase colorectal cancer screening
- to decrease the disparity in mammography rates between Hispanic women and the general population, and
- to improve outpatient care of congestive heart failure patients.

The colorectal cancer screening project examines how to best motivate beneficiaries to take advantage of Medicare covered colorectal screening. CFMC is testing the differences between gender specific and gender neutral motivational messages. Also of interest are the different degrees of impact based on the source of the message; CFMC or the patient's physician. Data are currently being collected.

"The projects . . . . will continue to evolve and new projects will be added."

The mammography rate for Hispanic women is 7% lower than the general Medicare population. While the national breast cancer project is looking to increase total mammography rates, CFMC's local project aims to reduce disparities. An innovative randomized trial incorporating the support of the Catholic

(Continued)

HCFA Focuses on Outpatient Care
(Continued)

Church and peer-educators seeks to build upon the very successful work by La Clinica Tepeyac in Denver. We have received strong support from the state Archdioceses and are looking forward to collaborating with the investigators at La Clinica.

Finally, several medical practices in Denver and Greeley have agreed to participate in an outpatient CHF project that will build upon the efforts of physician champions like Randall C. Marsh, MD. A prominent cardiologist practicing in Greeley, Dr. Marsh has engaged in a personal crusade to improve the care of CHF patients.

The projects described above and in previous articles will continue to evolve and new projects will be added. Our responsibility to improve the quality of health care in Colorado is not possible without the support of those who provide care and services. CFMC's commitment to evidence-based interventions insures that participating physicians will be rewarded with improved systems. Please take advantage of activities like the patient reminder cards. If you would like to take a more active role, or if you would like assistance with your own quality improvement program, please feel free to contact us.

CFMC
2851 South Parker Road, Suite 200
Aurora, CO 80014
303-695-3300
www.cfmc.org

Table I

Topic Area	Quality Indicator	CO % (n)	19 states* %(n)
Pneumonia	• Administration of influenza vaccination among all patients statewide age 65 and above.	74% (321)	66% (8,957)
	• Administration of pneumococcal vaccination among all patients statewide age 65 and above.	53% (309)	47% (8,743)
Diabetes	• Biennial retinal exam by an eye professional.	68% (12,535)	68% (665,053)
	• Annual HbAlc testing.	78% (12,535)	66% (665,053)
	• Biennial testing of lipid profile.	51% (12,535)	53% (665,053)
Breast Cancer	• Biennial screening mammography.	45% (131,556)	45% (266,992)

**Arkansas, Colorado, Delaware, Illinois, Kansas, Maine, Mississippi, Montana, New Hampshire, Nevada, New York, Ohio, Oregon, Pennsylvania, Tennessee, Utah, Vermont, West Virginia, Wyoming.*

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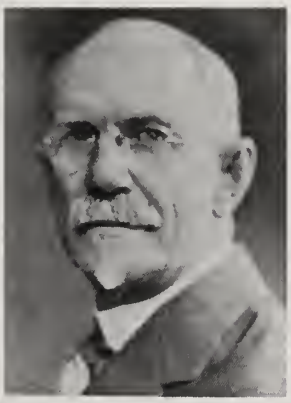
John L. Lightburn, MD
Historian
Colorado Medical Society

"A physician who dabbles in economics is apt to make mistakes, yet many of us feel that the doctors of economics of the present day are just as much at sea as we were in the trying influenza epidemic of 1918."
Gerald B. Webb, M.D.
in his presidential address

The Great Depression

On March 4, 1929, Herbert Clark Hoover was inaugurated as the 31st President of the United States. The country was experiencing unprecedented prosperity. Seven months later the stock market crashed and this nation and most of the rest of the world sank into the Great Depression which lasted throughout the 30's. Hoover had impressive credentials with years of service to the country and the world. Although he created several public works programs, the Reconstruction Finance Corporation, the Federal Home Loan banks, and vigorously campaigned against "unjustified fear", unemployment grew, banks closed, increasing numbers of children were malnourished, infant and maternal mortality rates increased and the country sank deeper and deeper into the worst economic crisis of its history. The people lost confidence in Hoover; some even blamed him for their desperate plight. Frankly, he was unjustifiably vilified.

By September, 1930, the economy was down but people believed prosperity was "around the corner." People were still paying their doctor bills and the annual meeting of the CMS in Pueblo on September 9-11 was well attended. At this meeting, William A. Kickland, M.D., F.A.C.S., our 60th President, delivered his presidential address entitled, "Some Problems in Medical Economics," an appropriate title for that time.



William A. Kickland, M.D.

Dr. Kickland was a well known surgeon from Fort Collins. He had some concerns about the unintended consequences of the rule against fee splitting by the American College of Surgeons. He agreed that the shameful practice of "buying and selling patients" had been all too common in 1913 at the time the American College was founded. Indeed, fee splitting had resulted in unethical behavior detrimental to the patient. On the other hand, "the public has been educated to pay the surgeon well and the internist very moderately." Thus the ban on fee splitting had resulted in serious inequities among the various branches of medicine. "There should be a readjustment in the schedule of fees charged for services in the different branches of medicine," said Dr. Kickland. Many of his colleagues appreciated this point of view. Even today some of us may think there are still some inequities. We thank Dr. Kickland for his efforts.

Edward Delehanty, a 63 year old neuropsychiatrist from Denver was our 61st president. He had come to Colorado in 1890 and his first job was principal of the North Golden school. Two years later, he started medical school at the University of Colorado in Boulder. At that time,



Edward Delehanty, M.D.

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the Dean of the medical school was Dr. Jeremiah T. Eskridge, a neurologist who was both Dean and Professor of Nervous and Mental Diseases. Dr. Eskridge's teaching and clinical skills deeply impressed the young Delehanty. After graduation, he served an internship at Arapahoe County (later Denver General) Hospital and an additional year as chief resident medical officer. After several years in general practice with Dr. P. V. Carlin, he decided to follow his mentor, Dr. Eskridge, and did graduate work in neurology, first at Vanderbilt and later in Vienna. His reputation as a neurologist and psychiatrist grew. He was instrumental in starting the mental advisory commission to the County Court (commonly called the "Lunacy Commission"). His skill as an expert witness was legendary. He was a likable, congenial man.

When he became president in 1931, he toured the state visiting the component societies. Wherever he journeyed, he brought with him a bag containing a supply of four ounce prescription bottles of good bourbon for each member of the traveling party. Proud of his Irish heritage, he had little patience with the 18th Amendment and Prohibition.

In one of the longest presidential addresses ever, Dr. Delehanty spoke about a number of issues of the day. Here is a summary of that address with some excerpts.

He first paid tribute to his mentor and role model, Dr. Eskridge, "whose eminence in his specialty was recognized by neurologists throughout the country . . . He died at the height of his career, being only fifty-four years, and succumbed to a neurological condition regarding which he had done so much original investigation, namely cerebral hemorrhage. It is a strange coincidence that his conferee for many years, Dr. Clayton Parkhill, that distinguished surgeon and teacher and co-worker with Eskrige, died on the same day of appendicitis -a disease of which he was recognized as a master."

Dr. Delehanty then turned the subject of the specialty of neurology which in his judgment was suffering a "decadence" or decline in esteem. He said neurological problems were now cared for by pediatricians, internists, neurosurgeons and even psychiatrists! "In the old days the neurologist was not only the neurologist of the general hospital and the community but he was also the psychiatrist. The psychiatrist confined himself to institutional work and the major psychoses." He added somewhat disdainfully that neuropsychiatrists have become numerous, and "neuropsychiatry concerns itself with psychic disorders but invades the realms of social medicine, eugenics and crime. The scene of their activities . . . has transferred to the market place, the schools and the courts." His listeners must have smiled, because they knew he was the preeminent expert witness in the courts of Colorado.

He told his audience that there was little help for the neurotic patient, and he doubted that Sigmund Freud's psychoanalysis could be of much help. "The stories of cures by these methods are mostly literary efforts", and he added, "Prophylaxis of the neuroses should be the chief aim of the physician." To this end he recommended support of the newly established Mental Hygiene Association. But there was one agency or association that he found difficult to support. I speak of the Association for Birth Control. It has solicited the influence of the profession and some have subscribed. . . It is a movement regarding which an illustrious president with the big stick coined the term 'Race Suicide'. . . the A.M.A. has not put its stamp of approval on its activities . . . .Mental wrecks are the end result." This stalwart Catholic Physician had little patience with Margaret Sanger and her "family planning".

Delehanty then paid tribute to the pioneer physicians of Colorado. "Those doctors of the old school had confidence in themselves and supreme confidence in the efficiency of drugs." They paid no heed to Osler's "nihilistic philosophy" but depended on their common sense and knowledge of their patients and "'put courage into the sinking heart of the sick by the absolute confidence in them."

He then reported that the CMS had grown from 143 members of forty years ago to the present membership of 1,096. Colorado had more physicians per capita than any other state except California. He also pointed out that the number of hospital beds in Colorado was one for every 2,232 inhabitants; this was too many. This created an unneeded expense. And "there has been no time in which the physician was as disturbed about the future of medicine and himself as he is today. . . They have suffered the loss of their savings over night and a 25 to 50 percent reduction in their collections." These were hard times, but closing hospitals would not have helped.

Our next president, 1932-33 was a Denver Roentgenologist, Frank B. Stevenson. He gave his presidential address at the annual meeting in Estes Park on September 8, 1932. On the minds of the delegates was Herbert Hoover's desperate but losing political campaign against Franklin Delano Roosevelt. They wondered if that radical Democrat would bring in socialized medicine? Unlike Ed Delehanty's address which was long and rambling, Dr. Stevenson's address was short, precise and dealt with one issue, "Public Health and the Medical Profession". With admirable preci-



Frank B. Stevenson, M.D.

sion and clarity, he defined the role of government and public health, the parameters of public health and preventive medicine and its relationship to the medical practitioner. "It is questionable," he said, "if it is fair to the public for the government . . . to establish and maintain with the people's funds free clinics or hospitals for treatment of disease, whether communicable or not, whether venereal, tuberculous or any other, in which treatment is offered or given to those who are able to pay for such service. . . I resent being taxed to cure my neighbor of a communicable disease. He should be forced to secure treatment at his own expense."

That said, he agreed that Public Health had a place and it deserved the support and cooperation of the medical society. "It is now a consistent further step to examine our state health administration. Is it functioning adequately? In 1930, a representative of the U. S. Public Health Service conducted an evaluation of all health agencies of Colorado and discovered serious deficiencies which were reflected in higher death rates from all diseases. The death rate from preventable diseases was higher in Colorado than in the neighboring states. Infant mortality rate was very high, 91.3 per thousand live births; in the surrounding states it was 68.0. After presenting a grim list of delinquencies, Dr. Stevenson said, "Granted, then, that the medical profession in Colorado should manifest greater interest in public health work, and that the state health laws need revision to adjust them to modem preventive principles and to create a more alert and efficient organization, I would suggest that the Colorado Medical Society undertake to stimulate its members to greater public health activity, and that an important step in that direction would be to urge and work towards improvement in Colorado's public health administration."

So this small, soft spoken, meticulous but gentle man had effectively spoken out against government involved in the medical care system, but cogently defines the need for a more modern health laws and health department. The state legislature was content with the status quo and Colorado would have to wait 15 years before Florence Sabin returned to bring about the much needed reform in our public health system.

The following year, 1933, the society met in Colorado Springs where Gerald Bertram Webb was installed as the 63rd president. Dr. Webb had come to Colorado in 1894 seeking a cure for his tubercular ridden wife. She survived only a few years, but Dr. Webb's determination to find a cure led him to research and a specialty that brought him international recognition. His Presidential Address gave dramatic evidence of how the deepening depression was impacting the medical profession. He warned his listeners that he did not have good news. "The time is out of joint and efforts are being made by all statesman to set it right. . . It seems incredible that the United States which came out of the war as a creditor nation, with nine billion dollars to loan, should now be in such a plight. . . .Our 7000 hospitals, to which three billion dollars have been given by churches and philanthropists, are now imperiled. . . . Running parallel with the depression is a decreasing birth rate and an increase in malnutrition in children. It results in unemployment and can not be excused in a country with over-abundance of food supplies." Community Chest of Denver provided relief to 3,572 cases in June, 1932 and 16,610 in June of 1933. How many of those are going hungry, and how many will succumb to tuberculosis?

In his address, he was surprisingly candid and open about the possibility of governmental intervention. "You are familiar with the reports of the Committee on the Cost of Medical Care . . . the majority report recommended the socialization of medicine and the minority report favored retention of individualism." He summarized other reports and articles which seemed to look with favor on "socialized systems" in Europe, England and even in the Soviet Union. The Soviet Union! The United States had not yet recognized that communist government. His predecessor, Frank Stephenson, must have bit his tongue to remain silent during this address. But Gerald Webb was not advocating socialism; he was telling his colleagues that in view of "the momentous changes in our economic system, which are



Gerald B. Webb, M.D.

accelerating like a falling body, the medical profession must take the lead without delay in formulating procedures in medical economics."

He concluded with "The wisdom of the past covers all our perplexities, but even with its help we must use our own intelligence in the trials which are new to us. The medical profession must instigate and advise without delay the best steps to be taken to meet the demand for adequate medical service in this new era. A powerful mental ferment is at work which the physicians should guide."

"Physicians should guide." That is our history lesson. Here is another lesson offered by Dr. Webb: "The virtue of prosperity is temperance; the virtue of adversity is fortitude."

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



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Upon renewal in 2000 of your Copic group or individual medical professional liability insurance (PLI) policy, some important enhancements will take effect regarding the Legal Defense portion of the coverage for eligible physicians. We're making these enhancements in recognition of changes in the healthcare environment.

- Coverage has been added for disciplinary proceedings instituted by health plans or other commercial payers. Previously, Legal Defense coverage offered reimbursement of qualified expenses incurred in defense of covered disciplinary proceedings instituted by a state licensing authority, a peer review body, or by state or federal agencies alleging Medicare/Medicaid fraud and abuse. With your renewal in 2000, Legal Defense coverage will also apply to covered disciplinary proceedings initiated by a private health benefit plan alleging billing fraud and abuse or performance of medical services in excess or violation of utilization guidelines.
- Coverage has been added for disciplinary proceedings alleging violations of EMTALA. With your renewal in 2000, Legal Defense coverage will also apply to disciplinary proceedings threatened or instituted by state or federal authorities alleging violation of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- We have removed the differing deductibles, incident limits, and aggregate limits for groups. Previously, group practices were subject to varying deductibles, incident limits, and aggregate limits depending upon the number of physicians insured under the group policy. Upon your renewal in 2000, all insured physicians will have the same $750 deductible and the same $25,000 annual aggregate limit, regardless of whether they are insured as individuals or as members of a group.

Some physician practices may desire higher limits for their Legal Defense coverage. A practice can apply for higher Legal Defense limits at the time of renewal by completing a supplemental application. The application is subject to underwriting review and approval, and the increased coverage requires payment of an additional premium. Applications for higher Legal Defense limits are available upon request to the Policyholder Service department.

We take our role as physician advocates very seriously. This advocacy means that a Copic policy doesn't stop at medical liability defense. It also provides a liberal death, disability and retirement benefit as well as HIV, long-term care, and legal defense benefits. We are extremely pleased to be able to incorporate these enhancements into our policy. We believe our eagerness to listen to our customers and adapt our product accordingly is one of the characteristics that sets Copic apart from other insurers. We'd like to hear from you. If you have suggestions for other ways in which Copic could enhance your coverage and ease the burdens of practice, please feel free to contact me or Mr. Kassal at (303) 779-0044 or (800) 421-1834. Be assured that we will evaluate all suggestions thoughtfully.

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Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

10-9-8-7-6-5-4-3-2-1-0: As Y2K became a reality hour by hour from the International Date Line around the world, it turned out to be "just another New Year's Eve." The fears of a global meltdown vaporized in the smoking trails of fireworks from Melbourne to Paris to San Francisco.

No doubt the extensive preparations of recent months averted a genuine disaster. Yet dire predictions persisted on many fronts, and even those who were confident of a smooth transition would admit to a bit of breath holding "just in case."

As CPN enters its fifth year, we have already outlived the expectations of the nay-sayers, and the realities of most other state medical society initiated managed care plans. Though our collective fingers remain crossed, we have not relied on mere magical hopes to survive. In fact, CPN and Rocky Mountain HMO are addressing the vital issues of intensified Utilization Management, experience-based premium pricing, aggressive Front-Range marketing, and realistic physician reimbursement. Each month Rocky Mountain HMO statewide moves higher into the black, though Front-Range losses are not yet under control.

We recognize that many of our members have not yet experienced a beneficial impact on their individual practices from CPN/RMHMO enrollment. Yet our world has neither stopped nor exploded: we continue to grow, and to believe that we will succeed despite the increasing chaos and complexities surrounding us. CPN **IS** Year 2000 compliant.

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Peer Review: No matter the outcome, these words can mean financial hardship, anxiety, and the loss of countless hours for physicians and medical organizations alike.

Colorado Personalized Education for Physicians (CPEP) can help. Nationally recognized, CPEP is dedicated to helping physicians assure excellence in patient care. CPEP has assisted hundreds of physicians around the country through its program of individualized assessment and education.

Physicians, hospitals, managed care organizations and state licensing boards rely on CPEP's in-depth analysis of physicians' skills. Moreover, CPEP's customized learning plans address peer review concerns when the need for educational intervention is evident.

With increasing pressure on physicians at both the local and state level, the need for this positive alternative has never been greater.

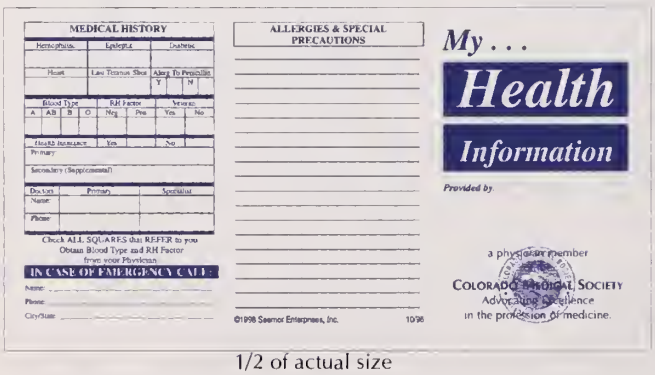
Are your patients fully aware of their medications?

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of their medications. They should know what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions. That's a lot to remember, and here's a way to help them.

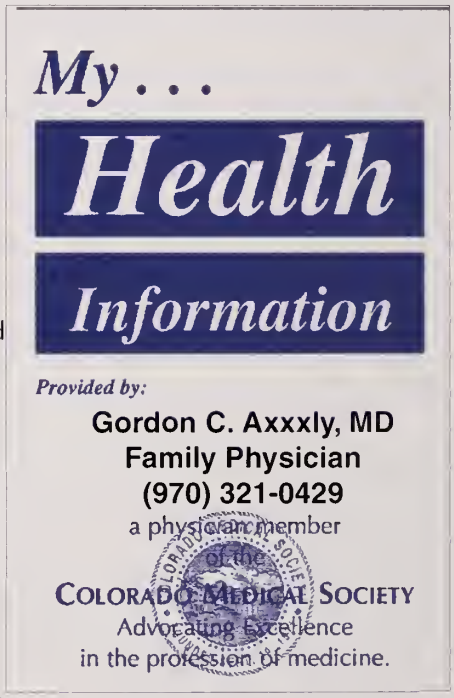
Every day you remind your patients to follow your directions exactly. Even so, we hear of patients taking seriously conflicting substances, such as using an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among older citizens.

Here is a device you can give your patients which will help them remember their current medications , the dosage and the schedule. It is a handy, pocket-sized card which is constructed of sturdy plastic. . . and the card can be written on if the prescriptions change.

The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as the medical needs change. The card will hold up a long time.



1/2 of actual size



Actual size of folded card

These health/medication records allow you to place **your identification** on the front in a space 3/4" deep by 2" wide. We at CMS feel that your patients will appreciate you for providing them with this, and will be a constant reminder of the quality of care and concern you have for their healthy well-being.

These cards are inexpensive; they can be ordered in lots of 100 @ $0 .40 ea = $40.00

200 @ $0.36 ea = $72.00

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These prices include postage paid delivery. Sorry, but we cannot handle any orders less than 100 right now.

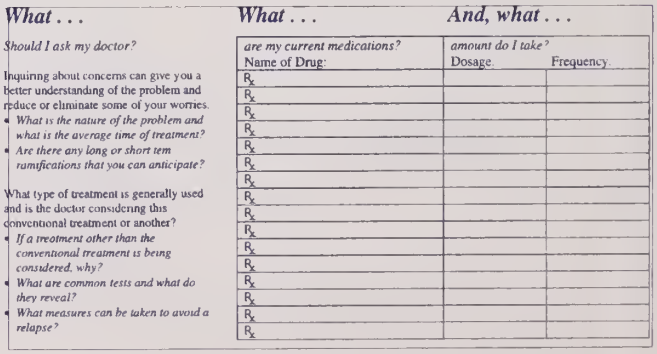
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A newsletter to provide medical office staff with information on health insurance

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RUMINATIONS

(**def:** chewing again what has chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor



A flush of success

In mid-December, 1999, I returned from the UK and landed at the Newark, NJ airport, I had to make a rather hasty decision, whether I felt badly enough to use the air terminal's public rest room. I have a thing about that, even though it is not a well-founded fear or risk. I still just don't like to do it, UNLESS it is a matter of dire necessity. This was a matter of dire necessity. It had been a long, uncomfortable, crowded flight.

I went into the men's room, found an empty stall and went in. I looked first to see if the Airport Authority provided "seat covers." They did. Do you remember what they look like? They're made of a heavy tissue with a cutout in the center the shape of the seat opening. The cutout IS cut out, with the exception of three places along the circumference of the hole. After being pulled loose from the uncut portions, that part which is cut out then drops down, hanging loosly from one side. Get the picture?

I don't know when you last visited one of these airport, bus or train station public rest rooms, but now most of them flush automatically. They work on a battery-powered electric eye: you approach the toilet and the eye senses you and flushes the thing. When you leave (moving out of the beam of the electric eye) the toilet flushes . . . to your departure.

Newark dumbfounded me, right from the start. I entered the toilet stall, closed the door and turned, reaching over the fixture to obtain a seat cover. I bent down and placed the cover on the seat. Just as I did, the toilet flushed with a mighty sucking, rushing sound, and quickly disposed of the new/unused seat cover. Sucked the cover right off the seat!

Sure enough on the second try, before I could gain the presence of mind to figure out how to stop the seat-cover, it was swept away as well, unused, un-crinkled. You see, the big problem is that when you place the seat cover down on the seat, that cutout piece in the center is still attached (to one side) and is hanging in the water. When the new flush comes, there goes the seat cover, pulled down by this unused portion of tissue. What's a man to do?

The third time, I said to myself "People outside must think I'm just standing in here flushing the toilet continuously." I tried again, with the same results. By this time, I was getting pretty "flushed" myself with anger. How can this SIMPLE machine keep outsmarting me? All it is is a large porcelain bowl, a water valve, a drain pipe, and a confounded electric eye!

I stood there, deep in thought, and it finally came to me: when you extract the seat cover from the wall dispenser, do not stop with detaching the three little tabs on the center cutout; tear off the entire piece of unused tissue so it does not hang into the bowl and get caught in the next flush. Also, be ready!

With my knickers draped loosely around my ankles, I was poised. I treated the tissue as I had planned, and finally it worked. . . on the fourth flush.

This brings up a rather interesting point having to do with the old saw, "Necessity is the Mother of invention," or some such. I started wondering how all these needs could be satisfied without wasting so much paper, time and effort. And then my next idea came to me: how about a press-on adhesive seat cover? The tissues could be coated with a light adhesive allowing the tissue to be easily removed without leaving any adhesive residue, and discarded as usual. The tissue seat covers come out of the dispenser folded in two, so the adhesive could be applied without the tissue "pre-sticking". When you removed the tissue from the dispenser, as it unfolds you simply pull off the paper covering from the sticky and the tissue seat cover is ready to apply (hopefully).

Actually, this isn't a bad idea. I think there's a market, especially in the Newark air terminal. Also, with the press-on adhesive, it really wouldn't matter which seat you stuck the thing on, yours or the toilet's. The cover would work the same in either place.

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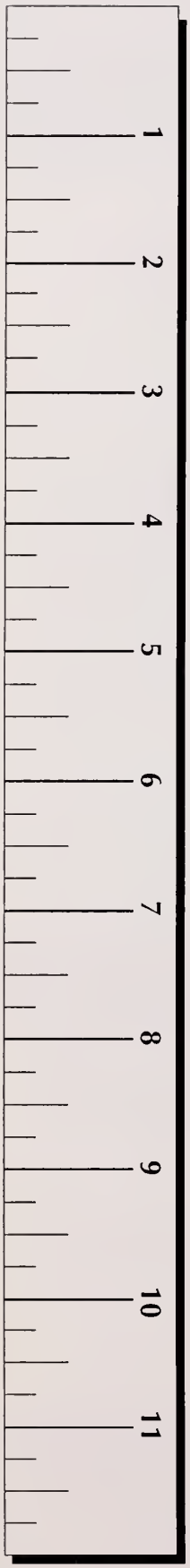
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Red Carnation - Symbol of "Doctor's Day," - Story of red carnation's place in medical science

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7800 E. Dorado Pl., Englewood, CO 80111. Telephone (303) 779-5455. Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

It is always nice for something we have been involved in to work out well. Such was the experience of our faculty and staff this weekend at the CMS spring educational meeting. The subject was End-of-Life care and the attendees were very talented and diverse in specialty and geography. It was exciting to see old friends there from Cortez to Ordway to Greeley along with urban and suburban physicians from the length of the Front Range. This speaks to the interest of all specialties in the burgeoning universe of palliative care.

While palliative care has been a part of medicine since the time of Hippocrates it has until recently been a system of lesser priority or last-ditch measures in the practice of most physicians. No longer. The EPEC curriculum developed by the AMA with a Robert Wood Johnson grant opens up the knowledge base and systems of care we can and must use when curative treatments are no longer effective. This excellent curriculum was presented by a local faculty that besides being very skilled, were different in another way. Their level of commitment to the cause of spreading the word about effective palliative care was astounding. The energy and empathetic commitment to their subject resulted in the best post-graduate education course I have ever attended. The attendees agreed as you will see from their remarks quoted elsewhere in this magazine.

Our CMS staff who worked hard on this project, especially Sandy Finney, must also be commended. I cannot praise them enough as they worked long and hard to make this educational conference a meaningful and substantive experience well worth the time of those who attended. Those of you who missed it missed something special, but there will be other opportunities. The faculty intends to continue their work and disburse this concept of palliative care across the state in whatever form needed by local entities, professional and lay as well. CMS should and will continue to be involved in the coordination of this effort. It deserves our support.

On to another matter. As many of you know I integrate some form of exercise into my travels for CMS. This has allowed me to take good weather walks in environments very different from the beautiful and empty prairies of eastern Colorado. Imagine my distress as I found during this meeting's walks, unbelievable numbers of physically and mentally distressed human beings adrift and unsheltered alongside clear demonstrations of our societal wealth. From the beautiful 16th Street Mall just this week, to the beaches of Santa Barbara within mere yards of mansions up the cliff, to the streets of our nation's capitol, the homeless and derelict abound.

Do they want to be there as some would assert? Possibly some do, but for most I think not. As I walked the streets of downtown Denver it was cold and wet. I was snug and warm in my gore-tex and gloves, but they looked miserable and I'm sure most were. I must admit feelings of guilt suffused me as I walked by without giving them something, but we all know that

"It did not take the diagnostic skills of this country physician. . ."

cannot be the answer; the solution to these problems is societal. But, I was moved to write about the problem and what we as physicians can do to work to solve such problems.

It did not take the diagnostic skills of this country physician to see that most of these people suffer from physical and mental ills poorly addressed by our current system of health care delivery. Lack of easy universal access is part of the problem. Certainly we have derelict souls in rural areas, but where there are not so many it is easier to meet their needs by some means and they are not often seen that unsheltered and untreated. What will it take to meet the unaddressed needs of these urban and suburban many?

(Continued)

President's Letter
Continued)

We must ask ourselves why are they there? The last time our society saw so many homeless and untreated was during the Great Depression and before WWII. As our society developed wealth and systems of health care available to most (individually purchased or provided through charity) most of these who needed help were provided for.

One answer might be society's and medicine's approach to mental illness. Many are aware of well meaning law and policies that in recent years emptied our mental institutions and nursing homes of huge numbers of mentally ill individuals. That would have been reasonable had the means to provide well organized, effective and accessible outpatient mental health services to this population that generally needs focus and direction.

We must finally treat mental illness and disability as we do physical illness and disability. They are after all much the same and integral processes, no where more demonstrated than in the homeless and derelict. Benefits of any health care program or system must place mental health on par with physical health for without either, neither can be whole. And, we must develop a proper system for the institutional provision of mental health care for those who cannot access or coordinate it themselves, even with help.

Physicians must be a part of the solutions to these issue through volunteer work, with empathetic care, through involvement with the efforts of organized medicine and legislatively. Without our involvement, experience as detailed above has shown society's reparative measures will not work appropriately.

(Dr. Berry can be reached by e-mail at ***jlberry@plains.net****)*

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. . . a compilation of medically-related news briefs of immediate interest to the physician community occurring after COLORADO MEDICINE has gone to press. **AT PRESS TIME . . .**

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society



Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Give Your Will A Check-Up

by Michael H. Smith

My experience has been that many people will either do their will or think about their will after the birth of a child or when they are getting ready to go on an airplane trip! Unfortunately, this approach may result in (1) a will which does not represent their wishes or (2)the payment of estate taxes which could have been avoided with a will containing the appropriate tax planning provisions. The purpose of this article is to identify the most common circumstances which generate the need to revise wills.

Do you need a tax planned will? The first will done by most people contains no tax planning. It will name a personal representative, a guardian for minor children, set up one or more trusts for the management and protection of property going to children, and provide for contingent beneficiaries in the event the entire family perishes. This is what I call a simple will and is appropriate for estates which will not be subject to the federal estate tax. In the year 2000 the threshold for a taxable estate is $675,000. This amount is gradually increasing through the year 2006 as follows:

2000 and 2001	$ 675,000
2002 and 2003	$ 700,000
2004	$ 850,000
2005	$ 950,000
2006 or thereafter	$1,000,000

If a married couple has a combined net worth, i.e., assets minus liabilities, in excess of this threshold, a simple will will result in estate taxes on the death of the second spouse which could have been avoided through the inclusion of tax planning provisions contained in their wills. For example, in the year 2000 a married couple with a combined estate of $1,000,000 could save approximately $125,000 in estate taxes by having tax planned wills as opposed to simple wills! In calculating your net worth for this purpose, one commonly overlooked item is the death benefits under life insurance policies. While life insurance is generally not included in income for income tax purposes, it is included as an asset for estate tax purposes.

Are your assets properly owned? Married couples who have tax planned wills need to review how their assets are owned. Generally, since the order of death can never be known, the best tax planning can be accomplished by having the assets owned as close to equally as possible. Equal ownership avoids wasting part of the applicable exemption amount if the spouse with the lesser amount of property dies first. Also, joint tenancy with rights of survivorship should generally be avoided since such property passes automatically by operation of law to the surviving joint tenant as opposed to passing under the will where the tax planning provisions are contained. Obviously, there may be non-tax related reasons for not owning property equally.

Review your beneficiary designations. Property such as life insurance, individual retirement accounts, 401K plans, other qualified retirement plans, and POD accounts do not pass by will but rather are paid (1) according to the beneficiary designations which have been completed by the owner or (2) pursuant to the default provisions of the relevant document if a beneficiary designation has not been completed. Therefore, it is extremely important to review your beneficiary designations on a regular ba-

(continued on next page)

sis to make sure that they reflect your desires and are properly coordinated with your will. For example, if a will establishes a trust for children in the event of the death of both spouses, the beneficiary designation of life insurance policies should normally name this trust as the contingent beneficiary. Otherwise, the insurance policies will be paid to the children's conservator and the proceeds will be turned over to the children at age 21. This is typically a much earlier time than would be established under most trusts.

Check your appointments. Most wills will appoint a primary and successor personal representative, guardian, and trustees. You should review these appointments carefully and make sure that the individuals named are appropriate, qualified and willing to serve. For example, ten years ago your parents may have been an appropriate guardian for your children. Now, however, that may not be the best for either your parents or your children. Consider the situation in which you have now acquired a million dollar term life insurance policy to take care of your children if something happens to both spouses. Is your sister who you originally named as trustee qualified to be the trustee of a much larger trust than was originally contemplated?

Have you planned for incapacity? In addition to a will, it is generally recommended that most people have financial and medical powers of attorney as well as a living will. The powers of attorney appoint one or more agents to make financial and medical decisions on your behalf in the event you are incapacitated. By executing these documents in advance, you avoid the time and expense associated with a legal proceeding to appoint a legal guardian. It is also generally advisable to execute a living will (call a Medical Surgical Declaration in Colorado) to indicate your intentions regarding life sustaining measures in the event of a terminal illness. Finally, even if your adult children do not have any significant assets, it is advisable for them to have powers of attorney and a living will in order to avoid unnecessary complications in the event of their incapacity.

Do you own real estate in other states? When a person dies there is generally a primary probate administration in the state of domicile. Additionally, there must be an ancillary probate in any other state in which the decedent owned real estate other than as a joint tenant or indirectly, such as through a partnership or limited liability company. Such ancillary probates can be more complicated if the other state has not adopted the Uniform Probate Code as has Colorado and add a great deal of cost to the probate process. In such circumstances you should consider placing the out of state property into a revocable living trust or perhaps a flow-through type tax entity, such as a partnership or limited liability company, to avoid the necessity of an ancillary probate.

While everyone's personal circumstances are different, a review of these areas will provide you a good foundation for determining whether or not you have an appropriate will and have planned for incapacity. If this article wasn't motivation enough, plan a vacation.

OIG Work Plan for 2000

Every year the Office of the Inspector General (OIG) publishes their work plan, that is, the areas they will be looking at during the upcoming year. This list is an indication of where they have concerns about potential fraud and/or abuse. Some of the physician services that are targeted for study are:

- **Physicians at Teaching Hospitals** - to verify compliance with the Medicare rules governing payment of physician services provided in the teaching hospital setting.
- **Automated Encoding Systems for Billing** - determine whether errors found in Medicare billings for physician services are associated with the use of automated coding software.
- **Reassignment of Physician Benefits** - evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. Looking for vulnerabilities as typically in these instances the physician never sees what is billed under his or her physician number.
- **Myocardial Perfusion Imaging** - assess the medical appropriateness of myocardial perfusion imaging and explain the high increase in utilization since 1997.
- **Private Physician Contracting** - study the impact the private contracting provision of the 1997 Balanced Budget Act has had on Medicare beneficiaries.
- **Advance Beneficiary Notices** - examine the use of advance notices to Medicare beneficiaries and their financial impact on the beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse.
- **Improper Medicare Fee-for-Service Payments** - this is a continuation of the efforts that began after auditors found that HCFA had spent billions of dollars on improper payments. (The infamous random prepayment

(continued on next page)

CMS Med Fax

review of E&M codes was a result of this audit.)

Some of the other non-physician areas the OIG is focusing on include:

- **HMO Profits** - compare the profitability of the Medicare lines of business with the operating results from HMOs' other lines of business.
- **Managed Care Organization Closings** - review to determine the impact on beneficiaries of recent closings of Medicare managed care organizations.

AMA Supports Patient Safety Goals; Cautions Against "Culture of Blame"

"The AMA supports President Clinton's goal of reducing health system errors and improving patient safety, and we agree with many of his proposals," said Nancy W. Dickey, MD, AMA Immediate Past-President. She added: "However, we are concerned that the proposal for mandatory reporting will not improve patient safety and may, in fact, have the perverse result of driving errors underground. Effective aviation safety programs have taught us that a culture of safety is created by avoiding a culture of blame." "The same principle," she said, "holds true for the health system."

Dr. Dickey said the AMA agrees with many of the President's proposals for the private sector and the government to take to improve patient safety. "However, the AMA is opposed to the expansion of mandatory reporting of medical errors. There is no evidence to show that mandatory reporting improves patient safety. Before we expand data collection activities we need to analyze existing state systems to determine the most effective use of finite resources." She concluded by saying, "The AMA appreciates President Clinton's statement of support for protecting the confidentiality of peer review activities. But we are concerned that the protection does not go far enough to promote the type of information sharing that would help create a culture of safety where all members of the health system can learn from and prevent errors."

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Recapturing the Soul of Medicine
March 29 - April 2, 2000
Seabrook Island, *The Conference Resort*
South Carolina (near Charleston)
Contact: (800) 621-8335

Second Annual Update in Geriatric Psychiatry & Geriatric Medicine
March 30 - April 2, 2000
Keystone Resort
Keystone, Colorado
Contact: (303) 315-9653 or *Linda.Hay@UCHSC.edu*

Endourology 2000
March 31, 2000
University of Colorado Health Sciences Center
Denver, Colorado
Contact: (800) 882-9153 or *www.uchsc.edu/sm/conmdedu/cmecal.htm*

4th Annual Ophthalmology Symposium
March 31 - April 1, 2000
Denver, Colorado
Contact: (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

40th Annual Conference on Legal Medicine
March 31 - April 1, 2000
San Diego Hilton Beach & Tennis Resort
San Diego, California
Contact: ACLM (800) 433-9137 or *info@aclm.org*

APC & EMTALA Compliance Workshop
April 6-7, 2000
New Orleans, Louisiana
Hotel Inter-Continental
Contact: 730-506-3292

Peripheral Arterial Disease for the Primary Care Physician
April 8, 2000
Loews Giorgio Hotel
Denver, Colorado
Contact: (303) 372-9050

Asthma Allergy Ski Day
April 9, 2000
The Great Divide Lodge
Breckenridge, Colorado
Contact: (303) 740-7239 ext. 126 or *www.AsthmaSkiDay.com*

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

American Educational Institute's Computers in Medicine - An Introduction
Ongoing through April 14, 2000
Various CO mountain locations + WY & UT
Contact: 800-354-3507 or www.aeiseminars.com

American Educational Institute's Computers in Medicine - The Advanced Course
Ongoing through April 14, 2000
Various CO mountain locations + WY & UT
Contact: 800-354-3507 or www.aeiseminars.com

American Educational Institute's Medical-Legal Update
Ongoing through April 14, 2000
Various CO mountain locations + WY & UT
Contact: 800-354-3507 or www.aeiseminars.com

Level II Physician's Accreditation Seminar
April 14-15, 2000
Radisson Hotel-Stapleton
Denver, Colorado
Contact: (303) 575-8763

Health Promotion Excellence in the New Century: Ascending New Heights
May 16 - 19, 2000
Adam's Mark Hotel
Denver, Colorado
Contact: Kate Demas (202) 408-9804 or *Kdemas@sophe.org*

4th Annual Symposium, Contemporary Approaches to the Management of the Risk Factors for Cardiovascular Disease
May 19, 2000
Denver, Colorado
Contact (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

Level II Physician's Re-accreditation Seminar
June 16-17, 2000
Antlers Adams Mark Hotel
Colorado Springs, Colorado
Contact: (303) 575-8763

5th International Conference on Pediatric Trauma
June 17-20, 2000
Vail-Beaver Creek, Colorado
Contact: (719) 365-5888 or *www.pedtraumaconf.org*

9th Annual Rural Health Conference
June 21-23, 2000
Gunnison, Colorado
Contact: (303) 832-7493 or (800) 851-6782

Teens and Trauma
June 29-30 and July 1, 2000
Grouse Mountain Lodge
Whitefish, Montana
Contact: (406) 752-1775

Colorado Academy of Family Physicians Annual Scientific Meeting
July 20-22, 2000
Sheraton Steamboat Resort
Steamboat Springs, Colorado
Contact: (303) 696-6655 or *E-Mail: cafp@iex.net*

Neurology Update
August 4-6, 2000
Aspen, Colorado
Contact: (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

How To Practice Evidence-Based Health Care
August 6-10, 2000
Vail, Colorado
Sonnenalp Resort
Contact: sharlyn.walling@uchsc.edu or call (303) 315-7606

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Thus far in 2000, I've had a lot of time to reflect. That can be good... or bad. My reflection was not so good. I became ill just before the end of December and couldn't shake it without going for complete rest. I have been a "Director in residence" (my residence) and operating by remote control, wired wireless, mobile, cellular, internet, e-mail. . . you name it, I felt 70% connected.

I missed the camaraderie of staff and the reassuring presence of physician leadership. We've communicated by phone or hand-delivered memo, and it isn't the same. There was, however, a great amount of satisfaction in two things: 1) knowing that staff is taking care of things for the organization (they do that whether I'm in the office or out), and 2) having the approval of the President and the Board to take this time and rebuild. Fortunately, physicians know that some times the only thing that can help is a lot of bed rest. But now I'm back (part-time) into the business at hand of the Colorado Medical Society.

The 2000 session of the state legislature is under way. You can get your update the same way I'm getting mine these days. . . from the CMS Web Page and *"Legislative Digest."* The Update is staying up to date! Our Government Affairs staff is staying busy holding the line on existing statutes, fortunately not drafting any bills at this time.

- As I wrote this I learned that the Rural Tax Credit Bill was passed by the House, meaning that we have a strong incentive for new physicians to settle and practice in rural Colorado in the physician-shortage areas. Thanks to testimony such as that given in Committee by CMS President Jack Berry, MD, the bill actually had little trouble in passing. We'll keep you posted as to how the proposal does on its way through the process.
- Timely Payment legislation (HB 1250) was signed into law in 1999 and has just now in effect; i.e., the law just was effective January 1, 2000, and the third-party payers have 30 days in which to pay electronic "clean" claims. Paper claims will be in limbo for 45 days before the third party payer has to take action (make payment or tell you why they're not paying). CMS has known that "Timely Payment" is not the best law ever, but it is a first step. There is no way to enforce the law. With our "Hassle Factor" project coming of age we can only hope that physicians' offices are learning to practice due diligence and monitor these claims payments carefully. From their experience we can see which parts of the law work, and which parts don't. Then we'll be ready for the legislative session in 2001 to improve the law.
- It's a relief to know that CMS will not be holding an interim meeting of the House of Delegates. For one thing, preparation for the meeting would come right on top of getting ready to move to the new building, and I know we couldn't handle both. Instead, there was an educational session, ***"Educating Physicians On End Of Life Care,"*** February 11 and 12 and was very successful. Dr. Berry and the Professional Services folks at CMS did an excellent job in assembling an outstanding faculty.

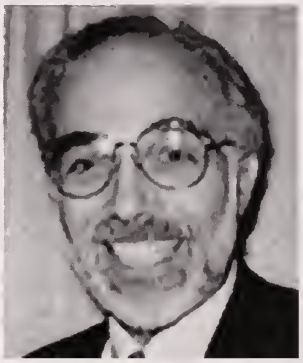
Medical Exile!

- March 3rd is the ***4th Annual Conference on Caring for Colorado's Medically Underserved,*** Even from my present exile, I knew that the conference was generating a great deal of interest. I hope the attendance will be as great. Colorado has long been a leader in the concerns for the medically underserved, as shown by the many free medical clinics operated by volunteer physicians throughout the state. This Conference on Caring. . . is an extension of that concern and serves Colorado healthcare providers well.
- The Board of Directors meeting was held January 21st. I was unable to attend. It's the first one I have missed since accepting this job. Fortunately, there didn't seem to be any highly critical items on the agenda. I'm still sorry to have to miss one.

Congratulations. . .

. . .to Mark A. Levine, MD who has been hired as the new Associate Medical Director of the Colorado Foundation for Medical Care (CFMC). Dr. Levine has spent over 20 years in the practice of Internal Medicare in Colorado and is a past president of the CFMC Board of Directors. He was recently the Executive Medical Director for HealthCare Colorado, a state-wide network of nonprofit hospitals. An expert in health care ethics. Dr. Levine is a member of the Board of Directors of the Rocky Mountain Center for Healthcare Ethics and served as Chair of the American Medical Association's committee to investigate the organization's controversial relationship with the Sunbeam Corporation.

CFMC, an Aurora-based, private, nonprofit organization with more than $10 million in annual revenue and 113 employees,



specializes in quality improvement and utilization review. Founded in 1970, the organization's largest clients include the Health Care Financing Administration's Medicare program, the state-managed Colorado Medicaid program, and the Department of Defense's TRICARE program.

Other new hires include: Beth Ketzenberg, Rich Kessel and Pamela Wolfe.



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Christopher J. Unrein, DO
Chairman
CMS Council on Legislation

Every year, the legislature faces a few bills about the scope of practice. These are bills that are overtly or subliminally intended to erode the practice of medicine. The ultimate goal of these bills is that professions that traditionally required the oversight of a physician seek to practice more independently. The main concern of the council on legislation is the well-being of our patients. The danger of these bills lies in the fact that the current cost-containment marketplace might use these newly unrestricted practitioners as "cheap physicians."

This year there are a few such attempts to expand non-physician practice. The first has late bill status and is expected to be introduced by a pharmacy group that desires to legislate collaborative drug therapy with physicians in nursing facilities. This is the second year in a row that this proposal has been brought forth. Last year CMS effectively lobbied against this bill and it was killed in the Senate Health Committee by the sponsor. This group promised to work with us over the summer to craft something that CMS might consider acceptable. No meetings were ever convened. Nonetheless, at the eleventh hour a bill did surface very similar to last year's without our input.

Our concerns about this bill are many. First is the nature by which it was brought forth. Another problem is the lack of regulation that this bill places on collaborative drug treatment. This includes the assumption that the physician signing the agreement would have to act in the capacity of an accrediting body. There is no restriction on how broad a therapeutic switch can be. The bill lacks sufficient criteria for a pharmacist to enter into collaborative drug therapy agreements and almost no limits to the scope of those agreements. Finally, there is no evidence that this can not already be done between a physician and a pharmacist under the delegation of the physician. Our legislature's efforts are better spent on the issues of the tobacco settlement and gun safety. One can only conclude that this is the first in a series of steps to erode the practice of medicine, by practitioners without the education and experience of a physician.

The next piece of legislation with which we are concerned is brought forth by the optometrists. The bill's title implies that it is intended to improve access to eye care for the Colorado patients. The bill's underlying argument is that access to eye care is insufficient in our state. The bill uses specific language stipulating that covered persons receive eye care without discrimination as to class of eye care provider as allowed by their license to practice. A subtle inclusion in this bill is the restriction that no health plans can require hospital privileges of an eye care provider in order to be on the panel. Albeit subtle, this is a small step toward equalizing the practice of ophthalmology and optometry, each of which has very different education and training requirements. It cannot be understated that direct access to eye care without a referral is good for our physician members, but this bill is crafted in such a way that the undermining of the practice of medicine will begin.

The final piece of legislation on our radar screen at press time is the rumor of a bill to define a scope of practice for EMTs. A group of EMTs on the western slope desire to be primary care providers and triage officers. The average EMT course is 80-120 classroom hours. A paramedic attends the equivalent to 1-2 years of junior college. The medical practice act defines these health care workers as physician extenders without a defined scope of practice. They seek to expand and change that. To believe that these individuals could act independently as primary cares providers is inconceivable.

Once again, the council on legislation faces issues on the scope of health care practice and the erosion of the practice of medicine. We are committed to our patients, to our physician members, and to that special relationship that bonds physicians and patients. We will continue to analyze legislation for pitfalls that are potentially intended to undermine the physician-patient relationship and the public safety. We will continue to ask the question, is it good medicine?

What's in the cards?

Not as important as what's ON the cards.



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Doctor's Day 2000

The Origin of Doctors' Day

Eudora Brown Almond was reared in the small Georgia village of Fort Lamar and from early childhood was greatly impressed with the selfless devotion of the medical profession's humanitarian service to mankind. She always carried in her heart fond memories of the gentle kindness of her family physician whose skill and understanding endeared him to his patients as both a beloved doctor and a revered friend.

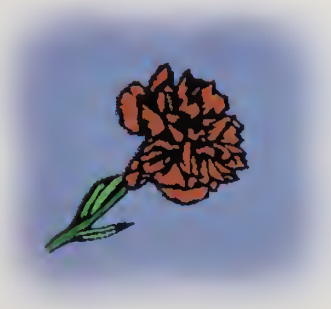
Because of her affinity for the medical profession, Eudora Brown was destined to become a doctor's wife. In 1920, she married Dr. Charles B. Almond and moved to Winder, Georgia, where they made their home. Their happy and busy life together serving their fellow men, was the guiding spirit which influenced her idea for a doctors' day. As she walked through the years beside her husband, sharing the dedication of his life to the practice of medicine, the charity and courage, love and sacrifices in his daily ministry of healing humanity's ills, Mrs. Almond became convinced that medicine is the greatest profession on earth, and doctors the greatest heroes. This respect and appreciation of the noble achievements of the profession inspired her to present to her local Auxiliary the idea of having a day on which to honor the practitioners of the Medical Arts. The suggestion met with immediate approval and the Auxiliary adopted the following resolution in 1933:

"Whereas, the Auxiliary to the Barrow County Medical Society wishes to pay lasting tribute to her Doctors, therefore, be it:
RESOLVED by the Auxiliary to the Barrow County Medical Society, that March 30, the day that famous Georgian, Dr. Crawford W. Long, first used ether anesthesia in surgery, be adopted as 'Doctors' Day,' the object to be the well-being and honor of the profession, its observance demanding some act of kindness, gift or tribute in remembrance of the Doctors."

The first Doctors' Day observance held was by the Barrow County Auxiliary on March 30, 1933. The Auxiliary mailed cards to the doctors and their wives. Flowers were placed on graves of the deceased doctors including that of Dr. Crawford W. Long. The ceremonies concluded with an elegant four course dinner at the spacious home of Dr. and Mrs. William Randolph with appropriate toasts, tributes and responses and the hope that hereafter, Doctors' Day would continue to be observed on March 30 of each year.

Mrs. Almond originally had in mind only Georgia's Winder and Barrow County doctors be honored. The idea, however, spread across the nation, even becoming a Congressional proclamation, to include doctors in all parts of this country. And so out of the gratitude of a little girl for her kindly family physician, and from the loving heart of a doctor's wife, justly proud of her husband whose work was his glory, emerged a most beautiful tribute to the medical profession:

The Red Carnation: symbol of Doctor's Day



Love -Charity - Sacrifice
Bravery - Courage

Doctors' Day - March 30.

HIGHLIGHTS OF THE MEETING OF THE BOARD OF DIRECTORS
January 21, 2000

A. **Copic:** Dr. Jerry Buckley reported that Copic has recently elected two new non-physician members to their board of directors, Ms. Virginia Berkeley and Mr. Bob Bigelow. He stated that Copic stayed within their budget for the year, and made a sizeable distribution to their insured physicians. The Colorado Credentialing Solution project has not received good reception from the national health plans, and so a legislative alternative is being discussed. Copic is working on implementing plans on how to help physicians, especially with referrals, authorizations, claims, and eligibility reports. The move to the new building is still scheduled for April 1, 2000.

B. **CMSA:** Ms. Joyce Wilson reminded the board that on January 28, 2000, the Alliance will conduct the CMSA Day at the Capital. Breakfast begins at 8:00 AM; there will also be a luncheon, and a cocktail reception that evening. She invited the board members and their spouses to attend.

C. **AMA Delegation:** Dr. Barbara Reed reported in Dr. Richert Quinn's absence. The AMA's expected budgeted revenue for the past year came up short again. The American Medical Accreditation Program (AMAP) is currently being studied by an independent company that may take over part of the program without involvement from the AMA. She then discussed a resolution on direct-to-consumer prescription drug advertising. This resolution was submitted to the AMA Interim Meeting at the request of the CMS House of Delegates. The resolution was amended, and then was adopted. Dr. Jeremy Lazarus stated that the subject of non-physician prescribing is a priority at the AMA. The other resolutions submitted by the Colorado delegation either passed or were referred. Dr. Jack Berry stated that Dr. Robert McCartney is planning to resign as AMA alternate delegate at the end of this year. Dr. Berry plans to run for the open alternate delegate seat.

D. Medical Executives Group: Ms. Judie Watson stated that Dr. Buckley spoke with them about helping Copic identify how Copic can assist physicians. Sandy Finney met with them to discuss recommendations from the Organizational Study Committee. These recommendations will be presented as resolutions to the House of Delegates at the Annual Meeting in September. The Medical Executives also viewed the video Clear Creek Valley created for their 65th anniversary.

E. **Colorado Physician Network (CPN):** Dr. Jeremy Lazarus stated that CPN is working on a pilot project with the physicians in Pueblo to raise their premiums and allow more reasonable physician reimbursement. Growth in the Denver metro area has been significant.

The board entered into executive session and at the end of the executive session, the following motion was made: **MSC to support the actions taken by the Colorado Medical Society President, Immediate Past President, and Executive Director and approve continued involvement regarding a judge's ruling relating to the jurisdiction of the Colorado Committee on Anti-competitive Conduct.**

The next board meeting will be held on March 17, 2000 at the Colorado Medical Society offices.



Colorado Medical Political Action Committee

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Louise McDonald, MD, announces candidacy for 2000-2001 CMS President-elect



Louise McDonald, MD. Speaker of the House of Delegates of Colorado Medical Society, has announced officially that she will be a candidate for 2000-2001 President-elect. The election will be held at the CMS Annual Meeting in September, 2000.

Dr. McDonald is currently the Associate Dean of the University Health and Counseling Services of the University of Denver, and is also the Medical Director of the University of Denver Student and Community Health Center.

Dr. McDonald's medical education includes her medical degree from the Georgetown University School of Medicine in Washington, D. C., a rotating internship at Harbor General Hospital, Torrence, California, a pediatric residency at Harbor General Hospital and the UCLA School of Medicine in Los Angeles. Dr. McDonald is certified by the American Board of Pediatrics. She has been a Denver resident since 1990, and has been active in the Denver and Colorado Medical Societies since 1995.

She also serves as a member of the Board of Directors of the Colorado Physician Network. Dr. McDonald was president of the Denver Medical Society in 1998-99 and is presently chair of the DMS Board of Directors.

Colorado Medical Society Foundation

Reprint from "Rural Health News," Vol. 6, No. 1 Fall 1999

RURAL HEALTH NEWS

Tracking Changes in Rural Health Care

Medical Society Helps Rural Areas with Recruitment an Equipment

The Colorado State Medical Society is reaching out to its rural communities and offering a helping hand on a range of issues.

Since 1997, the Colorado Rural Outreach Program (CROP), a project of the Medical Society's Foundation, has finished two funding cycles with support for eight rural and medically underserved Colorado communities. The Medical Society established the grant program after failing in its effort to have the state legislature fund a loan repayment program to help rural communities recruit health care personnel. "These communities come to us with their needs," says Anita Albrecht, Colorado Medical Society Foundation director. "We try to be broader than just loan repayment and also provide grants that help with retention."

For more than a year, a private practice physician and a nurse practitioner were on-call every night at tiny Haxtun Hospital in northeastern Colorado waiting for a new physician to replace a retired 20-year veteran. Finally, a family practice physician was recruited, thanks to a $10,000 educational loan repayment grant to the community from CROP.

"The big issue for a new physician is debt-load," says Jim Brundige, Haxtun Hospital's administrator. "In order to be competitive, we have to offer loan repayment." With CROP's help, Haxtun was able to piece together a $34,000 package, which netted them a new physician.

At the other end of the state, Weisbrod Memorial Community Hospital in the small town of Eads was able to upgrade its cardiac telemetry unit with a $2,400 grant from CROP. I'We were able to match the CROP grant and buy a rebuilt unit, something we sorely needed," says Marvin Bishop, hospital administrator.

Not many state medical societies mount this kind of effort to assist rural communities, says Linea Davis, public information officer for the American Medical Association.

In addition to CROP, the Colorado Medical Society Foundation coordinates the state's Coalition for the Medically Underserved, initiated by the Medical Society and representing a broad coalition of health professionais, legislators, foundations, insurers, and consumer and business groups. It aims to assure all Coloradans unimpeded access to quality health care by 2007.

Colorado Medical Society

2000 Leadership Conference Registration Form

May 6-7, 2000 • Sonnenalp Resort, Vail

❒ I plan to attend the Leadership Conference to be held May 6-7 at the Sonnenalp Resort in Vail, including dinner on Saturday night.

❒ My spouse/guest will attend the Conference and dinner on Saturday.

❒ My spouse/guest will not attend the Conference but will come to dinner on Saturday night.

_____ _____

Name Component Society

_____

Name of Spouse/Guest (if attending)

Mail to CMS, P O Box 17550, Denver, CO 80217 or Fax 303-771-8657.

Sonnenalp Resort of Vail

Group Name: Colorado Medical Society

Name:_____ Phone #: ( ) _____

Address: _____

City: _____ State/Zip: _____

Number in Party _____ Arrival Date: _____ Departure Date:_____

Credit Card Information:

Please Note: A deposit equal to one night's stay will be charged to your credit card. Balance is due upon check-out.

Check one: ❒ Mastercard ❒ Visa ❒ Diners Club ❒ American Express

Credit Card Number: _____ Expiration Date:_____

Cardholder's Name: _____

Special Seminar/Conference rate will be extended to attendees for longer stays.

Desired Accommodations:–Bavaria Haus Suites: ❒ King Bed ❒ 2 Double Beds

$135 (plus 9.9% tax) per night, Single or Double Occupancy – Number of Units: _____

Bavaria Haus suites all contain gas-log fireplace, large baths with soaking tub big enough for two, separate shower, heated tile floor, walk-in closet, TV, VCR, fully-stocked mini-bar, hand-carved pine Bavarian furniture, and down comforters on all of our beds.
There will be an additional charge of $25.00 per night for each person over 12 years of age exceeding Double occupancy.
(Note: most suite types cannot accommodate more than 3 adults.)
Reservations received after April 21, 2000, will be taken on a space available basis only.
Cancellation Policy: In the event of cancellation 14 or more days prior to arrival, you will receive a full refund. If you cancel less than 14 days prior to arrival, you will forfeit the deposit of one night room and tax.

Reservations will be taken with this form or call our Reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort of Vail, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

2000 Leadership Conference

Each year, Colorado Medical Society's President-elect hosts a leadership planning conference to put forth the agenda for the coming program year. The President-elect for 2000-2001 is Dr. Richard Allen. For the 2000 Leadership Conference, Dr. Allen has chosen to work with the CMS Committee on Professional Education and Accreditation, preparing a conference with major emphasis on lifelong learning.

Medicine in the Next Millennium: A Return To Professionalism

The conference will be held May 6-7, 2000, at the Sonnenalp Resort, Vail, Colorado. All CMS members are invited to attend.

Focus of the conference is to "reinvigorate professionalism and physician pride." To accomplish this end, the program revolves, in a very upbeat fashion, around the future of medicine while stressing the fundamental need for lifelong learning.

Two areas are being further emphasized: Education of the physician, and Genetics. The objective of the latter portion of the conference is to expedite and incorporate the appropriate new findings into clinical practice, especially in relation to advances in genetics research. Genetics is being used as a current example of the need for physicians to realize that the science and technology of the future is now.

Saturday's schedule begins with a presentation on Medical Professionaism by Dr. Matthew Wynia from the Institute for Ethics. This will be followed by panel presentations (15 minutes each) and discussion (45 minutes) from Dr. Richard Krugman, Dean of the University of Colorado School of Medicine (medical education); Drs. Harry Jonas and Frank Simon (Division of Graduate medical Education), Dr. Vincent Fulginiti (medical education in academic health center). In this portion, the emphasis is placed on the future and the need for lifelong learning, ethics, and professionalism. This program seeks to incorporate the topic of "mentoring" medical students and residents as a responsibility, an avenue for passing along the legacy, and a means for modeling professionalism.

Saturday afternoon is free for reflection, recreating and/or spending time with the speakers. There will be a dinner Saturday evening followed by a special presentation by Dr. Jonas which everyone, including spouses, will enjoy.

Sunday morning's program, May 7th, will deal with genetics, preceded by a presentation of futurist Jeffery Bauer, PhD.

Following Dr. Bauer, Dr. Richard Spritz will give attendees an overall picture of what is occurring in genetics research. A panel will discuss ethical considerations, dilemmas encountered in practice and indications of continuing education to meet the needs of this new medical research.

The Sonnenalp Resort of Vail has been a highly successful venue for the Leadership Conference for a number of years.

The future's plan

In CMS' 2000-2001 program year, President-elect Dr. Allen wants to see a "return to professionalism" which has highlighted medical practice for many decades.

Dr. Allen says, "I see this being stymied and eroded away in all aspects of medical practice and academic medicine. There are ways in which renewal of professionalism can be attained, but it must come from within."

Dr. Allen added that "an integral part of the quality of medical practice is lifelong learning by physicians. We hope to focus our efforts in the coming year on these aspects of the practitioner's life."

On an accompanying page you will find registration details for the conference and a reservation form for the Sonnenalp.
For further information, contact:
Lorraine Heth, Program Mgr.
(303) 930-0409 or
Lorraine_Heth@cms.org

Physicians and Pacificare Face-Off

Reprinted from the Denver Medical Bulletin, Vol. 90, No. 1, January, 2000

"Several physicians .... expressed frustration with the burdensome referral process ...."

Responding to concerns of physicians arising from the termination of the relationship between PacifiCare and Millenial, the Denver Medical Society sponsored a forum on December 14, 1999 featuring Val Dean, MD, PacifiCare Chief Operating Officer and Executive Vice President. The purpose of the forum was to provide an opportunity for physicians to understand the current status of PacifiCare physician contracting and to voice their own concerns about the state of physician contracting in Denver. DMS President Elaine Scholes, MD prefaced the discussion by acknowledging the tension in the current environment but called upon participants to maintain a level of civility. Her request was honored and after two hours of frank and open dialogue moderated by DMS past chair and president Glenn Foust, MD, the 75 attendees and Dr. Dean both agreed that it had been a valuable and timely exchange of information and viewpoints.

Contract negotiations were still ongoing at the time of the forum with several physician organizations which had been part of Millenial, Dr. Dean reported. At the same time, PacifiCare is offering individual contracts to physicians for both their commercial and Secure Horizons (Medicare HMO) plans. In response to physician comments addressing the practice of shifting financial risk to physicians, Dr. Dean commented that some of the physician organizations with which PacifiCare contracts continue to do well managing risk and are still committed to risk-based contracting. Others, he agreed, had had disappointing experiences and PacifiCare would likely be more careful in structuring risk contracts with physician organizations in the future.

Dr. Dean shared his opinion that some physician organizations had taken on too much or inappropriate risk in past contracts. He contended that in some cases this was done against the advice and preference of health plans. Some organizations also took on administrative functions for which they may not have been prepared. Specifically, he mentioned difficulties with delegated claims processing by several groups. At least one physician in the audience supported Dr. Dean's contention that some physician organizations had pushed to assume more responsibility than PacifiCare had sought to transfer.

Many physicians in the audience expressed their opinion that physicians should not be placed in risk-bearing relationships for both ethical and practical business reasons. Concerns were voiced that risk contracting creates an inherent conflict between the physician's duty to the patient and their own self-interest. The inability of relatively small physician groups to adequately manage the financial risk of a limited patient pool was cited as one reason that assuming risk does not make business sense for most physicians. The cost and resource requirements to create adequate infrastructure to address the information management demands of capitation were also identified as barriers for most physician groups which participants on both sides agreed tend to be undercapitalized. PacifiCare will be exploring alternative reimbursement models but Dr. Dean made clear that uncontrolled fee-for-service was not an option.

Difficulties with "PODS"

Several physicians in the audience expressed frustration with the burdensome referral process required to provide specialty care and with the limitations on specialty referrals created by the "pod" (or "integrated health care team") system employed by PacifiCare. Physicians were critical of PacifiCare literature which they feel promotes the availability of a broad network of specialists to health plan members while contract incentives encourage primary care physicians to limit referrals to a small subset of network spe-

(Continued following page)

(Continued)

cialists. Dr. Dean acknowledged referral problems created by the pod system but insisted that the creation of physician contracting groups had been driven by the desire of many Denver physicians to exert more control over medical resource management. Limiting specialty networks was seen as consistent with primary care physicians' traditional tendency to work with a limited number of specialists with whom they had had good experience. According to Dean, reimbursement terms in capitated contracts were configured to offset some of the potential negative financial impact when patients see specialists outside their primary physician's pod.

Several physicians responded that the problem of "pod jumpers" - patients who change primary care physicians in order to gain access to a specialist in a different pod and then change back - created a financial loss for the new pod which incurred the specialty care costs without the benefit of the ongoing capitation payment.

Some specialist physicians also complained about barriers and limits placed on referrals which interfere with optimal patient care. With the assumption of medical management by physician organizations, Dr. Dean responded, those organizations now set the rules for referrals and, he claimed, have imposed more stringent requirements than PacifiCare had previously utilized. Some members pointed out that this was a logical response to the incentives created by capitation and pods and underscored the need to jettison this model of health care delivery.

There seemed to be a consensus among participants that the "pod" system as currently configured had not functioned particularly well for anyone - physicians, health plans or patients. The clear message that PacifiCare has received from employers and plan members has been, according to Dean, that they want networks with broad choice. This conflicts with a model which emphasizes medical management and fiscal discipline through integrated physician groups.

Shared Challenges

Dean agreed with members of the audience that a new vision for delivering health care is required and admitted that he did not know what that vision should be. He expressed his personal regret that more of his time is now spent on managing chaotic business relationships, and less of his time is directed toward seeking system-wide ways to improve care. Although the audience's level of frustration and bewilderment following their experiences with various unsuccessful models was evident, Dr. Dean and others expressed the belief that physicians must take a leadership role in redefining a rationale health care system. DMS Treasurer David Downs, MD observed afterwards that this was the most important point to him. "The fact that Dr. Dean acknowledged that the current model isn't satisfactory and that it is incumbent upon physicians to step forward and envision something better - that's a tremendous opportunity for further dialogue. The DMS wants to ensure that that opportunity isn't lost," Downs said.

When the discussion turned to specific operational issues it was again apparent that the complexity and multi-level nature of current arrangements compounded the difficulty of isolating and correcting problems. Any one of several administrative layers at either the physician organization or health plan level might be the source of the difficulty. The issue of timely payment was raised by a physician who accused health plans of intentionally stalling payment in order to "play the float." Dr. Dean categorically denied that PacifiCare relied on interest earned by delaying claim payments and indicated that the vast majority of electronic claims are paid within 5 days. An administrator at one practice challenged that data by relating an ongoing problem with claims submission and approval of referrals which they were experiencing. Dr. Dean responded by asking for specific information at the end of the meeting and promising to research the problem, find its source and resolve it.

At the end of the evening, the problems facing Denver physicians had not be solved but it did appear that the goal of improving communication had been met. Participating physicians expressed appreciation at having had the opportunity to express their views and complaints directly to Dr. Dean and to consider his responses. Dr. Dean acknowledged the thoughtfulness and validity of many of the issues raised and expressed his willingness to be apart of further efforts to increase dialogue and seek a better vision.

The intent of DMS in sponsoring this program was to help Denver physicians deal with an immediate crisis - not to offer a solution to, as one participant said, the "managed care hell" in which some find themselves. "I was struck by the fact that many of the things physicians complain about are mutual concerns shared by the health plans," Jim Regan, MD, DMS President-Elect stated. "The meeting was a valuable exchange of information and a good starting point for further dialogue," he concluded. DMS efforts in this arena will continue with a follow-up meeting on January 25 featuring a panel of local physician organization leaders to explore the organizational and contracting options open to physicians and how these may evolve in the future (see page 3 for complete program information). DMS is also arranging a speaker from the AMA to discuss physician opportunities for collective bargaining. We also intend to pursue dialogue with health plans, physician organizations and anyone else who is interested in exploring ways in which the environment for medical practice can be improved and physicians regain control of their professional lives. Let us know your thoughts and suggestions on how this goal can best be reached.

COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

Lucinda Hammond,
Daniel Feikin, MD,
Kenneth Gershman, MD, MPH,
Richard Hoffman, MD,MPH;
Colorado Department of Public Health and Environment

Vancomycin Resistance and Vancomycin Use Policies in Colorado Hospitals

"Multiple studies have shown that vancomycin use is a risk factor. . ."

In the United States, there has been a rapid increase in rates of infection and colonization with vancomycin-resistant enterococci (VRE) since 1989. The Centers for Disease Control's (CDC) National Nosocomial Infections Surveillance (NNIS) system indicates that the percent of VRE (high-level resistance) among nosocomial enterococcal infections in ICUs increased from 0.4% in 1989 to 13.4% in 1993[1] and 23.9% in 1998[2]. Vancomycin use has increased dramatically since the 1980s[3] in parallel with the emergence and spread of MRSA infections. The main concerns stemming from this situation are the lack of effective antimicrobial therapy for VRE infections and the possibility that vancomycin resistance genes can be transferred to *Staphylococcus aureus* or *S. epidermidis*.

The Colorado Department of Public Health and Environment (CDPHE) conducts sentinel surveillance for VRE in Colorado based on reporting by participating hospital laboratories. From July 1998 through June 1999, the overall rate of VRE (defined as intermediate or high-level resistance) among all non-stool enterococcal isolates in 33 selected hospitals was 4.2%.[4] By region, the highest rate was in the Denver metropolitan area (5.6%). These data are similar to those from several other states that conduct VRE surveillance,[5,6] but substantially lower than those reported from New York City.[7,8]

CDPHE conducted a telephone survey of Colorado hospitals during the fall of 1999 to assess current practices regarding prudent vancomycin use. The intent was to provide information to CDPHE to assist with the development of strategies to further address vancomycin resistance in Colorado. All 66 non-psychiatric Colorado hospitals were contacted by phone and asked to participate in the survey. The ten-question survey was administered to the first person reached who felt qualified to answer questions; the respondents included pharmacists, clinical coordinators, or pharmacy managers.

We asked about aggressive restrictions on vancomycin use. These included: approval of the pharmacy, pharmacist, or infectious disease physician; completion of a special order form; or automatic substitution of oral metronidazole for an oral vancomycin order. We also asked participants about less aggressive pharmacy restrictions on vancomycin use. These included automatic stop orders for vancomycin and routine recommendations of alternative antibiotics for inappropriate vancomycin orders

Of the 66 hospitals, six were ineligible because they did not have on-site pharmacies or did not carry vancomycin. For an additional nine hospitals, an appropriate respondent was unavailable for survey despite repeated attempts. Of the 51 participating pharmacies, 45 (88%) had at least one type of policy regarding the administration of vancomycin (Table). Thirteen (29%) of the 45 hospitals with policies had an aggressive restriction policy in place. The median duration of these aggressive policies is four years.

Of the 45 hospitals with vancomycin use policies, 23 (51%) have conducted some type of evaluation of vancomycin use. The majority of these evaluations consisted of drug utilization reviews to establish the appropriateness of use. Evaluation results were not requested as part of the survey. Of 44 respondents who estimated vancomycin use over the past five years, 84% believed use had remained the same or actually increased.

To assess type of policy by hospital size, a distinction was made between hospitals with less than 150 beds (small) and hospitals with 150 or more beds (large). Large hospitals were significantly less likely to recommend alternative antibiotics compared with small hospitals ($p=0.03$, Chi square test). No other significant differences in type of policies were found between small versus large hospitals.

Seventy percent of respondents felt that restrictions would be an effective way to limit vancomycin use in their facilities. Several respondents felt that physician resistance would render such restrictions ineffective.

Our survey of hospital pharmacies showed that most hospitals in Colorado have some sort

Vancomycin Resistance
(Continued)

of policy towards curbing the inappropriate use of vancomycin. Yet only about a quarter of the hospitals surveyed have what we would consider an aggressive policy towards vancomycin restriction. This figure is comparable with a recent survey of Oregon hospitals.[9]

Multiple studies have shown that vancomycin use is a risk factor for infection and colonization with VRE. In addition, the few patients who have been infected with vancomycin-intermediate *S. aureus* had histories of extensive use of vancomycin. Several studies of vancomycin use restrictions have shown mixed results in terms of reducing the prevalence of VRE. One study in which physicians were required to complete a special order form on the computer justifying the use of vancomycin showed a decrease in colonization with VRE.[10] In another study, restriction of vancomycin, as well as cefotaxime (another documented risk factor for VRE), use led to a decrease in the point prevalence of VRE fecal colonization from 49% to 15%.[11] Two other studies, in which infectious disease approval was required for non-ICU use of vancomycin and use of vancomycin beyond 72 hours, did not show a significant decrease in VRE after the interventions.[12,13]

The CDC guidelines published in 1995 outlined 12 situations in which vancomycin use is deemed inappropriate. The Oregon study revealed that, overall, the two main indications for which vancomycin was inappropriately prescribed were routine surgical prophylaxis and empiric treatment of suspected gram-positive infections. They found, however, that individual hospitals often had a single indication that accounted for most of the inappropriate vancomycin use in that institution, a finding confirmed in a recently published study from an academic medical center.[14]

With these findings in mind, the Colorado Department of Public Health and Environment (CDPHE) recommends that all Colorado Hospitals conduct periodic utilization reviews to identify ongoing inappropriate vancomycin use and develop interventions to address ongoing inappropriate vancomycin use. CDPHE has collected a number of utilization review forms for vancomycin in use at various hospitals and will make examples of these available to all hospitals to assist in these activities. CDPHE can also provide consultation to hospitals on the implementation of vancomycin use policies and utilization review activities. For more information, contact Dr. Ken Gershman at 303-692-2657.

Existing Policies Regarding Vancomycin Use Among Colorado Hospitals (N=51)

*Policy Type**	*Existing Policy* N (%)	*Written Existing Policy* N (%)
Require Pharmacy Approval	7 (13.7)	5 (9.8)
Require ID Physician Approval	3 (7.3)**	2 (4.9)**
Require Special Order Form	4 (7.8)	4 (7.8)
Automatic Substitution***	1 (2.0)	1 (2.0)
Recommend Alternative Antibiotics	40 (78.4)	20 (39.2)
Issue Automatic Stop Orders	29 (56.9)	28 (54.9)

* Non-mutually exclusive categories

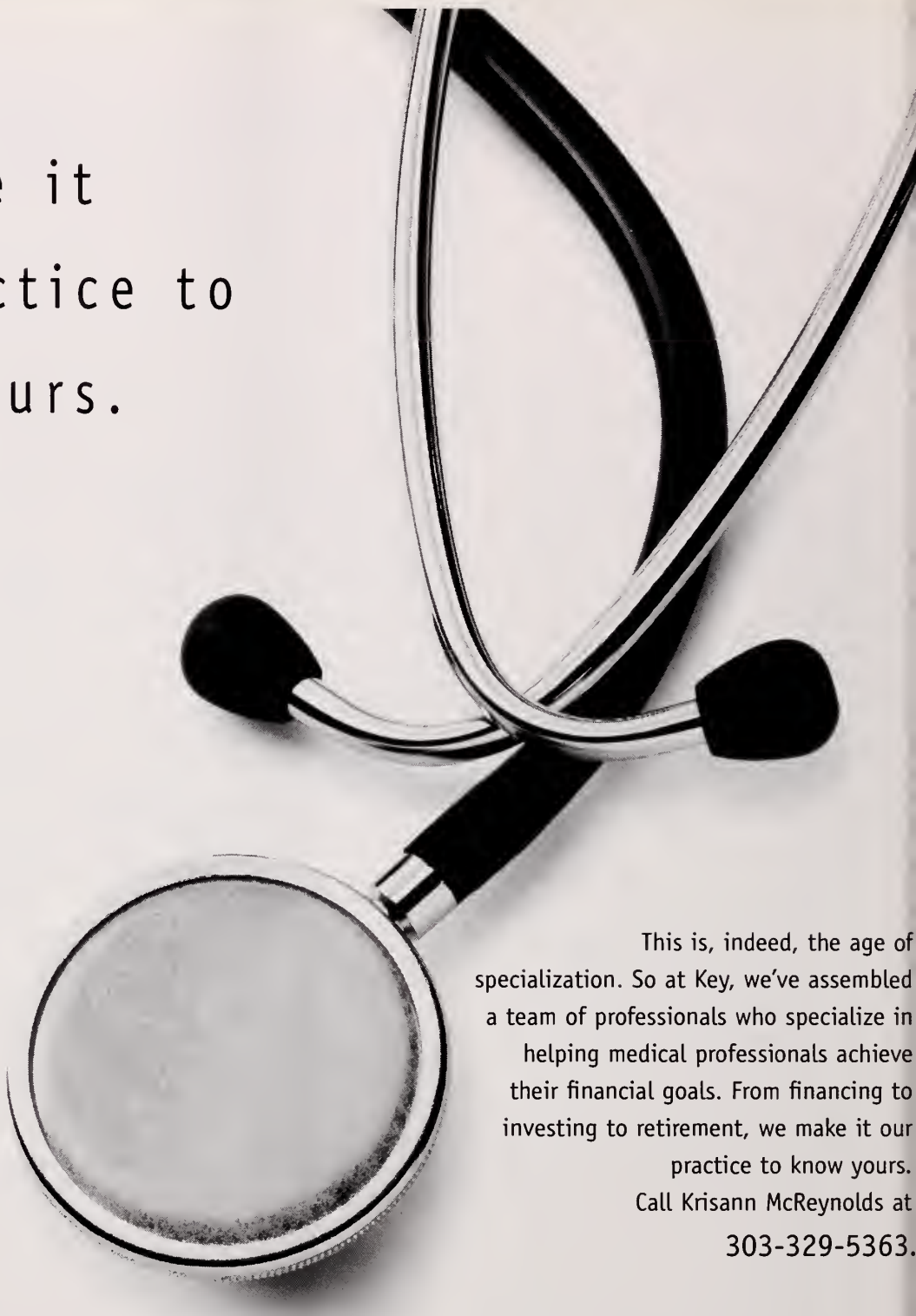
** This percentage is based on the 41 surveyed hospitals with infectious disease physicians

*** Automatic substitution of metronidazole for p.o. vancomycin for treatment of antibiotic-associated colitis

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John L. Lightburn, MD
Historian
Colorado Medical Society

More history lessons from the Great Depression

"But of all the other stupendous inventions, what sublimity of mind must have been his who conceived how to communicate his most secret thoughts to any other person, though very far distant either in time or place? And with no greater difficulty than the various arrangement of two dozen little signs upon paper? Let this be the seal of all admirable inventions of man."
Galileo

So with words from another time, we learn from the not so secret thoughts of our predecessors, thoughts provoked by distant events unlike but similar to those of today. Our colleagues of the 1930s were confronted with patients whose drastically diminished incomes resulted in needed medical care being unavailable. There were patients who needed care and there were hospitals and physicians who needed patients. The farmers had created an overabundance of food and there were poor children ill from malnutrition. Thirty percent of the work force was unemployed in 1932. After four years of massive public works programs, the unemployment rate was still 20%.

Conservatives were alarmed at the growth of the Federal government and the national debt. In their national convention, the Republicans nominated Alfred Landon, Kansas governor and a fiscal conservative who had balanced the state's budget. After his nomination, governor Landon came to Colorado for a two week vacation in Estes Park before launching his campaign for election to the presidency. He might as well have spent the next three months relaxing in that lovely resort, because on election day, poor Alf Landon carried only Maine and Vermont. The medical community was faced with at least four more years of Roosevelt's New Deal.

Many proposals for social legislation were presented to the congress. One was a plan for unemployment, old age and sickness insurance. This was known as the Social Security Act The provisions for old age and unemployment insurance were passed. Now the liberals in congress were preparing to pass legislation for National Health Insurance. "Socialized medicine" seemed to be a distinct possibility! There may have been a few physicians who agreed with those Washington social planners, but there were many, especially the CMS leadership, who were convinced it would destroy the practice of medicine as we knew it. Non-medical authorities would have control over what treatment the doctor could provide for his patient. This would be harmful to the physician/patient relationship.

As we struggle with the dilemma presented by Managed Care, it may be instructive to see how the CMS presidents responded to the liberal Washington establishment. Nicholas Madler, a Greeley surgeon, was the 64th CMS president (1934-35). "NicK" Madler had extraordinary organizational talents which had served him well when he led a bitterly contested effort to reorganize and standardize the Weld County Hospital. This hospital gained national attention because it was a publicly owned, tax supported hospital in which both indigent and fee paying patients were cared for by the same doctors who were compensated by tax moneys and private fees. Dr. Madler saw no reason why the public and private sector could not collaborate. He had many colleagues who disagreed with him, but they respected him and chose him to be their president.

He brought the same organizational skills to the CMS where his leadership brought about a complete reorganization with a rewriting of the Articles of Incorporation, the Constitution and the Bylaws. Organization and process were his concern, and he had little to say about the dangers of socialized medicine. His concern was chaos and uncertainty. Here is what he said in his presidential address: "Much of the past progress of the medical profession has been attained through its organization. It's future progress, to an even greater degree, is dependent upon this factor. Rugged individualism as a concept has become largely discredited; to many it has become a joke. The people of this nation have learned, at enormous expense, that a desirable and secure future cannot be achieved except through planning and cooperation."

(Continued)

These words of wisdom were not shared by the men who succeeded Dr. Madler during these troubled times. His successors during the rest of this decade were Walter W. King, a general practitioner, (65th president, 1935-36); Arthur J. Markley, a Denver dermatologist, (66th President 1936-37); W.T.H. Baker, a Pueblo surgeon (67th President, 1937-38); Leo W. Bortree, Colorado Springs internist (68th President, 1938-39); and John W. Amesse, Denver Pediatrician (69th President, 1939-40). Reading their presidential addresses reveals that they thought the foremost problem facing the profession at that time was the growing threat of some form of national health insurance. There were other important issues: the passage of a Basic Science Law; a bitter battle with the Chiropractors who were trying to persuade the voters to pass a constitutional amendment which would have allowed practitioner of any healing art to be licensed by their own board and to practice in any state supported facility. Other concerns facing the profession were the an infant and maternal mortality rate that was much higher in Colorado than in the rest of the nation; an inadequate state health department that had little control over domestic water supply, sewage disposal (every major stream in the state was polluted) or the dairy industry. There were also continued complaints that Colorado General Hospital was admitting non-indigent patients.

Here is a thumbnail sketch of those five presidents. Nick Madler was followed by Walter W. King who, unlike Madler, extolled the virtues of rugged individualism. He had started practice in 1900 in Cripple Creek right after his graduation. He loved that bustling mining town and the town loved him. Amazingly, the Cripple Creek district had a population of 50,000 and there were over 50 physicians caring for them. Dr. King described most of his Cripple Creek colleagues as rugged individuals. Some came to society meetings carrying six shooters. None of them would tolerate an outsider telling them what to do. In 1918, the Republicans nominated him as their candidate for the state senate. He had no interest in the office; he was too busy caring for the many patients ill from the influenza epidemic. But this solidly Democratic county loved their doctor and elected this Republican even though he was too busy to campaign. He was reelected to a second term, and after eight years in the state senate, he moved to Denver and continued his practice there.



Walter W. King, MD

In his presidential address, delivered in Estes Park on September 5, 1935, he said, "In these United States . . . we are swept along by irresistible demands for change.... we need to HOLD TIGHT WHERE WE ARE." He said a recent report from Washington on the high cost of health care read like pages from Karl Marx. He described physicians in the west as rugged individuals who do not submit to advice from outsiders. In contrast to his tirade, he finished his address urging that an endowment fund be established for CMS. Complying with his request, the next House of Delegates established the Colorado Medical Foundation. Even though he relished the memory of those tough minded, individualistic doctors of an earlier time in Cripple Creek, he was committed to the collegial community of the CMS.



Arthur J. Markley, MD

Arthur Markley was a cultured southern gentleman, perhaps a tad more dignified than his predecessor, Dr. King. He was widely known for his quick but accurate diagnostic skills. However, his skills were not limited to the field of medicine. When lecturing on dermatology or speaking of the dangers of socialized medicine, he was articulate, instructive and persuasive. Here is an excerpt from his presidential address: "In the medical field as in other fields there is today a conflict between a new reality and a desire to retain an old form. What should we do? Shall we stand aside letting things go on and then complain if we dislike the development; or shall we take an active part in the evaluation that is certain to come?" Words from the past as relevant today as they were 65 years ago.

Dr. Markley loved music and played both the violin and the piano until scars on his fingers from x-ray burns forced him to give up both instruments. For many years he was Professor of Dermatology and Syphilology at the University of Colorado.



W. T. H. Baker, MD

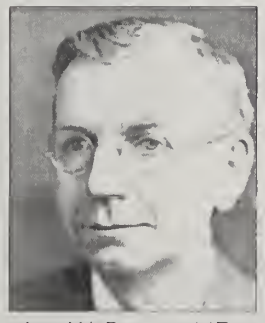
Dr. W.T.H. Baker came to Colorado in 1897 to join Dr. R.W. Corwin who was the head of the medical department at the Colorado Fuel and Iron company in Pueblo. He was superintendent of the company's Minnequa hospital. In 1910, he left to go into private practice with Dr. Herbert A. Black. Later he and Black, with two other physicians, organized the Pueblo Clinic and still later founded the Parkview Hospital. This started years of bitter competition with the other clinic in Pueblo headed by Dr. Crum Epler. Neither Baker nor Epler would speak to each other until a short time before Baker became CMS president.

Dr. Baker devoted the major portion of his presidential address to two problems: First he discussed in detail the proposed amendment to the state Constitution that would allow chiropractors or any other healing art to be licensed by their own

(Continued)

licensing board without approval of the Basic Science Board. He urged all physicians to educate and agitate against this amendment. He then spent the remainder of this address describing the National Health Insurance Bill 855. He described its cost and the provisions which place the physician under the control of a governmental bureaucracy. President Roosevelt was just six months into his second term and his liberal friends had plenty of time to establish a state health plan; Baker thought it was crucial that Roosevelt be stopped.

Leo Bortree, our 68th president, was a self effacing man whose modesty belied his brilliant mind and ability to write literary gems in simple but exquisitely chosen language. Better yet was his delightful sense of humor. He grew up in Colorado Springs with his widowed mother. He was graduated from Colorado College and Harvard with honors. Although he later described his presidency as one of profound mediocrity, it was he who led the successful campaign to defeat the constitutional amendment concerning chiropractic licensing. In his address, delivered in Estes Park on September 8, 1938, he said, "One of the major dangers facing medicine today is state control." He described how physicians have always been independent and they must continue to resist control by lay persons. He was gratified that for the first time in history, the Federal Government had asked for the advice and cooperation of the AMA in the National Health Conference. He warned, "Mass production methods cannot be successfully applied in the treatment of human beings who are ill. They remain individuals . . . . there has developed . . .a new profession, that of the Social Welfare Worker. Motivated by the highest ideals . . .of an altruistic profession, the activities of the welfare worker has added not a little to the problems and difficulties of our profession." He cautioned that there was a danger that the social worker in her role as advocate for the indigent will begin to tell the doctor what treatments are needed. This comes close to lay supervision of medical practice. However, he did agree with the concept of health insurance and praised the Denver Medical Society in developing a pre-payment plan for medical care and hospitalization. "As we survey the general picture of the medical world today, it seems inevitable that some form of group practice is going to become the rule." He urged his fellow physicians to actively "do what we can to protect our interests and thereby the interests of our own patients."



Leo W. Bortree, MD



John W. Amesse, MD

John W. Amesse, our 69th president (1939-40), came to Denver in 1911. After finishing his internship in 1899, he joined the Marine Hospital Corps (later the United States Public Health Service) where he spent twelve years doing public health work. He resigned from the service and went to Johns Hopkins for a pediatric residency. He then came to Denver to begin a very successful pediatric practice. John was a cheerful, enthusiastic man known for his funny stories. His young patients loved their buoyant, smiling doctor.

It was on October 5, 1939 that Dr. Amesse gave his presidential address, entitled *"The Shifting Frontiers of Pubic Health."* Dr. Amesse was uniquely qualified to discuss the evolution of public health as a medical specialty, as a concern for the entire profession and as a governmental function and responsibility. Here is an excerpt from his address: "While the original function of public health was but an elementary approach to proper sanitation, we now find the health officer and the practicing physician cooperating in the control and subjugation, not only of contagious diseases, but of such major disorders as cancer and mental illness. Together they organize and administer centers for immunization, maternal and child care, services for crippled children, venereal clinics and many other undertakings." So patient care had slowly become a function of the health officer. For example, Surgeon General Tom Parran's successful campaign against venereal disease involved not only identifying but also treating the infected person. Although John Amesse was dedicated to the AMA and had served for years in the AMA House of Delegates, he was much less vociferous than many of his colleagues about the dangers of government sponsored medical care. He agreed with the AMA House of Delegates when it accepted four of the five recommendations of the National Health Conference. These were:

1. Expansion of Public Health and Maternal and Child Care
2. Expansion of hospital facilities.
3. Medical care for the medically needy.
4. Insurance against loss of wages during sickness.

The fifth proposal for compulsory health insurance was unanimously defeated.

I am not sure why Dr. Amesse was less vocal about the dangers of "state medicine". Perhaps he assumed Roosevelt was coming to the end of his second term and would no longer be a threat. Maybe the whole profession was becoming more mellow or maybe there was another, more troubling danger on the horizon. Five weeks before Dr. Amesse had delivered his address, Adolph Hitler has sent his Nazi legions into Poland on September 1. England and France had a mutual defense treaty with Poland and declared war against Germany on September 3rd.

World War Two had begun.

Kenneth R. Cohen M.D., F.A.C.P.
Medical Director, New West Physicians

New West Physicians Type 2 Diabetes Outcomes Project

Colorado Quality Improvement Success Story

". . .the improvement was even more marked and was greatest in the specific areas. . ."

In March of 1999, New West Physicians (NWP) initiated a two-phase outcomes project to measure and improve care in type 2 diabetes mellitus (DM). NWP is a 65 physician primary care "clinic without walls" group practice model with 14 practice sites.

Despite the natural obstacles present in all physician practices, NWP was able to demonstrate significant improvement throughout the group in just nine months. The goals of the project were to accurately measure outcomes and identify areas for improved care with minimal disruption in office workflow and a limited budget. The group was successful in reaching these goals and has applied for American Diabetes Association Provider Recognition.

Phase one constituted a pilot project which encompassed four sites, 13 physicians, and 275 patients. Initially, 30 measures were studied through chart abstraction and patient interviews. Patient interviews were expensive, time consuming, and added little insight.

Of the 30 measures, the 12 which were felt to best represent quality measures in diabetes care were used for the final project.

The results of phase one allowed us to establish baseline quality measures. These results were shared in two ways. First, a "diabetes benchmark physician" was chosen to meet with the physicians at each site to review individual results and establish areas for improvement. Next, an educational paper was published describing areas for improvement and circulated via newsletter to all NWP physicians and mid-level providers. This article delineated the aggregate results of the pilot group as well as focused on the areas identified for improved diabetes care.

Phase two involved sampling 931 patients of the 42 physicians who were identified as having an adequate sample of DM patients. A major limitation of similar studies performed by insurance plans has been statistically meaningless data resulting from an inadequate sample size for each physician. As such, a sample size of 25 patients per physician was established. The final results allowed an average sample size of 22 patients per physician while 88% of the group met the target of 25 patients. This study was limited to chart abstraction and encompassed only the 12 most sensitive measures identified in the pilot project. The project was completed in December of 1999.

In terms of overall outcomes, NWP met or exceeded published standards in most quality measures with the exceptions of screening for proteinuria and proportion of patients with blood pressures in the target range of<140/90. When comparing the overall group results to the pilot project results, there were statistically significant improvements in several areas including documentation of diabetes well care, glycemic control, and lipid management. This improvement was felt to be related to both the educational paper and the "study effect" (whereby more attention is paid to patients with DM due to the ongoing study). When comparing the initial and final results of just the pilot group of physicians, the improvement was even more marked and was greatest in the specific areas identified for improvement including screening for proteinuria, enhanced blood pressure and lipid control, and use of the diabetes flow sheet. For the 12 measures studied, the pilot group of 13 physicians showed improvement of at least one standard deviation in 61 instances compared to a worsening of at least one standard deviation in only 13 instances. Additionally, a separate analysis was done to measure whether there was any effect attributable to the use of the diabetes flow sheet. Interestingly, the levels of glycated hemoglobin were not

(Continued on following page)

statistically different. This suggests that glycemic control is the main focus of diabetes care and that the flow sheet is not needed to focus attention on maximizing control of the glycated hemoglobin. However, when the flow sheet was in use, many additional measures improved including regular monitoring of the glycated hemoglobin, blood pressure, and lipids, control of lipids, and screening for proteinuria. Wellness measures including eye exams, foot checks, and pneumococcal and influenza vaccinations also improved.

This independently initiated quality improvement project was a success. We met our goals of collecting meaningful measures for a statistically significant sample of patients per physician with restricted resources. The chart abstraction, data collation, and analyses were done by three individuals with input from the office staff limited to pulling and reshelving the charts. Physician input was not required other than to review and act upon the study results. The pilot study was useful in identifying baseline quality data and served to identify specific areas in need of improvement and the best means to measure future outcomes. In only nine months, statistically significant improvements were seen in all of the identified measures. The results were embraced by the physician group and served as one of the performance measures which determined the physician's quality bonus in the NWP compensation model.

Acknowledgment: We would like to thank Ambient Health Technologies for the design and implementation of the project, and Bristol Meyers Squibb for providing an educational grant.

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The Wyeth-Ayerst (formerly the A. H. Robins) Physician Award for Community Service will not be offered by the company in 2000.

It is likely that this award will be discontinued. In this respect, the Colorado Medical Society wishes to continue this important physician service recognition, and will do so based on the same qualifications required in past years.

We invite your nomination for the

Colorado Medical Society

Physician Award for Community Service

and we remind you of the qualifications:

The physician must:

1. Be a member in good standing of the Colorado Medical Society, licensed to practice medicine in Colorado;

2. Be recognized for outstanding community service, separate and apart form his/her medical service or activities.

We wish to honor the physician judged by his/her colleagues to have contributed most significantly to civic activities and the community good. All nominations must be accompanied by documentation of the physician's community services; i.e., testimonials from community leaders, honors and awards received by the nominee for outstanding community projects, testimonials from peers, friends and associates.

Address all nominations to:
Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550

Nominations must be received by Midnight, July 31, 2000, to be considered. The award will be presented at the 2000 Annual Meeting in September, 2000, at the St. Regis Hotel in Aspen, CO.

This information supplied by the Colorado Rural Health Center

Site of *"Rural Health Conference 2000"*: Gunnison, Colorado

The County Fairgrounds in Gunnison, Colorado, is the site of the 9th Annual Rural Health Conference, June 21-23, 2000, The Colorado Rural Health Center is sponsoring this statewide event consisting of educational speakers, informative workshops, stimulating breakout sessions, networking, and fun for everyone.

The conference is open to anyone who has an interest in rural healthcare issues. The 1999 conference in Alamosa boasted over 200 participants from 31 counties in Colorado. Healthcare fields represented included public health, rural and urban hospitals, rural health clinics, state, and federal government, insurance companies, home health agencies, educational institutions, senior groups, and consumers.

The 2000 conference will include keynote speakers from national, state, and local levels. Speakers include Jim Wescott, State Demographer; Wayne Meyers, Director of the Federal Office of Rural Health Policy; Darin Johnson, lobbyist for the National Rural Health Association; and George Sibley, professor at Western State College. Hands-on workshops allow participants to gain a skill they can take home and use in their community. Workshop topics are fundraising, grant writing, assisted living, community needs assessments, and modern medicine & old techniques. Breakout sessions focus on a certain hot topic in rural health like poison control, emergency medical systems & trauma, underserved dental areas, and the rural nursing shortage are among this year's topics.

In addition to the regular exhibits, this year's Resource Potpourri will offer a community resource section of community service organizations. They will offer hands-on tools and resources to address local issues. The Resource Potpourri provides an opportunity for participants to learn about and network with organizations from across the state. According to Julie Jackson, conference coordinator, spaces in the Potpourri are filling up fast, but there is still room for additional booths. Call the Center if your organization is interested in participating.

Early bird registration fees for the conference will be $180 for Center members and $230 for non-members. Registration brochures will be available by the end of April.

The Colorado Rural Health Center was established in 1991 as the first non-profit State Office of Rural Health in the country, and remains one of the only state offices organized this way. Its mission is enhancing healthcare in Colorado by providing information, education, linkages, tools and energy toward addressing rural health care issues. The CRHC has a statewide membership of over 300 people and organizations. Its Board of Directors is elected by the membership and comprised of a majority of rural Coloradans. The 9th Annual Rural Health Conference is sponsored in part by ***Colorado Access.***

If you are not a member of the Center and would like to receive a brochure, call to have your name added to the conference mailing list. For more information about the Rural Health Conference or the Colorado Rural Health Center, call the Center office in Denver at (303) 832-7493, or from rural Colorado at

1(800) 851-6782

or email to

info@coruralhealth.org.

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



"If I Could Fix Just Three Things about Medicine in Colorado..."

"If I could fix just three things about medicine in Colorado, I'd _____ , _____ and _____." How many times has that thought crossed your mind? When it did, how did you fill in the blanks? Did your "wish list" involve finding a better way to verify eligibility and obtain referrals and authorizations under managed care? Maybe it was help with overhead, contracting, or appropriate reimbursement. Perhaps it was more altruistic, involving finding ways to meet the needs of the medically underserved and provide care in Colorado's rural areas. Regardless, it's probably a safe bet that each of you could name (at least) three aspects of practicing medicine in Colorado that you'd like to see changed.

As much as I'm interested in knowing what your answers would be, I'm even more curious to know this: How many of you have done something about your wish list? We can all do a good job naming the causes behind our symptoms. But how many of us have taken steps to get our wish lists in front of those who can help find the solutions? Have we been part of the problem, or a meaningful part of the solution? This is not meant to be a harangue. (Putting an end to harangues is probably on every physician's wish list.) What I'm getting at is this: While one person alone doesn't always have the power to affect problems on the scale we're considering, the combined power of many people does.

These days, it seems there's a support group for anything that ails you. I can think of at least four support groups for physicians who want to improve the way medicine is practiced in this state. They are your local medical society, the Colorado Medical Society (CMS), the Colorado Society of Osteopathic Medicine (CSOM), and Copic. When you make your desires known to these organizations, your voice and the voices of others in the healthcare community are amplified and multiplied.

To varying degrees, each of these organizations has what I refer to as "The Four Ts" - Time, Talent, Tools, and Treasury - that it can use to address problems. In its 19 years of operation, Copic has been fortunate to develop and acquire significant talent, tools, and treasury. Copic's Board and staff see themselves as stewards, ensuring the best and most effective use of these resources - not just to achieve Copic's goals, but to assist in meeting your needs as well.

How will the organizations that comprise your "support groups" know how to use their resources? They'll need to be willing to ask. As I said in a recent letter to Elaine Norman Scholes, M.D., president of the Denver Medical Society, "Copic would like to participate in any way we can to facilitate a continuing grassroots effort of identifying and addressing physicians' needs." In the coming months, Copic will be working with organized medicine to improve and expand the ways in which we learn about your needs.

Make no mistake, though. When these organizations ask, you'll need to be willing not only to tell, but also to participate in developing, evaluating, and implementing solutions. The best people to solve physicians' problems are physicians. Copic, your local medical society, CMS, and the CSOM are here to support you. We're committed to learning about what's most important to you and finding ways to help, and we ask for your commitment in return.



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The ***CMS Office Manager*** is a genuine Medical Office Resource.

CMS publishes a bimonthly newsletter dedicated to providing the physician's office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on staff analysis of the problems facing the physicians' offices. The newsletter is free to the office staff of CMS members, Non members can subscribe to the newsletter at a cost of $75.00 per year.

If you are currently not receiving the newsletter in your office, please copy this form, complete it and **FAX** it to Marilyn Rissmiller at (303) 771-8657, or mail it to P. O. Box 17550, Denver, CO 80217-0550.

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School of Medicine



Richard D. Krugman, MD, Dean
University of Colorado School of Medicine.

State of the School

"Back in the early 1990s, academic medicine was warned that managed care was coming. . ."

I recently had a conversation with one of my senior faculty members, Dr. Henry Claman, professor in allergy and clinical immunology. We were talking about what it was like at the School of Medicine when we came here from New York in the 1960s. It was different!

The School had 80 students in a class, no clinical enterprise to speak of other than the rare patients who came to see us for our clinical research activities or patients without insurance, and a growing research enterprise stimulated by Adult and Pediatric CRC's. We sent out no bills and collected money occasionally.

It was a growing, close, interactive and fun place to be. But lest we yearn to go back to those days, I am reminded that the average annual salary for a faculty member was $20,000, less than what our current interns are paid.

In 1979, one of our larger issues as a faculty was trying to get the resources to build a faculty dining area where we could interact over lunch. Now, most faculty don't have time for lunch. Most of us find that our 7 a.m. to 7 p.m. schedules are giving new meaning to the term "a half-day of work."

Through the years, the faculty and administration of the School have faced a lot of challenges, and the past year was no different. Last September, the federal government raised the bar for complying with government regulations of research involving human subjects, causing us to temporarily suspend our clinical trials.

We are not alone in dealing with this problem. Other outstanding medical schools, such as UCLA, Duke and Alabama, have also been confronted with compliance issues regarding clinical trials. For our part, we have taken steps to correct and expand our procedures with the Colorado Multiple Institutional Review Board (COMIRB), which reviews biomedical and behavioral research involving human subjects. We are now closer to restoring all of our research trials. To date, about one-third of the studies have been revived, and the remainder should be reviewed by this summer.

Some might say that compared to the COMIRB matters, talking about anything else is like asking Mrs. Lincoln, "Other than that, how was the play?" However, let me try, for the balance of the School's challenges are not only less contentious, but it most cases have a positive side to them.

First, the good news. Last fall, we admitted the best medical, physical therapy and Child Health Associate classes. The entering medical students, for example, had average MCAT and GPA scores above the national average. The students ranged in age from 21 to 37 (average age 26); 51 percent were male, 49 percent female. Compared to many of our peer institutions, we are in good shape financially. The School's revenues for 1998-99 were $275,360,278, of which more than $109 million came from clinical revenues and $127 million from grants and contracts. However, while our research and clinical funding have more than doubled over the last decade, our state funding and tuition have not, rising at less than half the rate of the others. Therefore, we have set a goal of having a $500 million endowment by the year 2010.

Our clinical revenue remains strong. Back in the early 1990s, academic medicine was warned that managed care was coming and not to be left standing without a partner when the music stopped. Other academic institutions, such as Penn and Allegheny, spent millions of dollars buying practices. Other, liked Cornell and Columbia, merged hospitals and bought a half dozen others.

We took a different approach and developed health plans such as Colorado Access and Tricare. Our goal was to have 250,000 lives in

CU - State of the School
(Continued)

our plans by 1997. We have exceeded that. While AAMC data indicates that all practice plan revenue dropped 3.9 percent last year, ours increased 9.3 percent. Rather than ranting at managed care, we have practiced it.

Our relationships with our affiliated hospitals are solid with regard to our absolute commitment to grow, develop and maintain superb clinical programs. As a practice group, we will need to be accountable to ourselves and to our partners such as at The Children's Hospital and University of Colorado Hospital to maximize our clinical productivity.

Seventy-five years ago, the School of Medicine moved from the university's Boulder Campus to its present location at the Health Sciences Center. Next year we will have a split campus to manage, as the School begins the move to the CU Fitzsimons Campus. Fitzsimons will provide relief to our critical shortage of space for research and education activities.

I've thrown several dates around in this column. Let me give you a two more. On May 13, 2000, we will stage the CU Medicine Ball and launch the fund raising effort to achieve $500 million in endowment. The occasion also will mark the 117th anniversary of the CU School of Medicine. I'm not sure any institution has ever celebrated a 117 birthday in such a fashion.

Finally, I want to tip my hat to the school's faculty, chairs, center directors, senior associates, assistant deans and students for facing a lot of challenges together and achieving the success we have.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

By the time you read this piece, I will be in "retirement." After thirty years of internal medicine, hematology, and oncology in Colorado Springs, I feel it is time to transition to other responsibilities.

Although I anticipate more discretionary time for family, friends, and creative interests, it is my intent to continue to be involved in both clinical and administrative medicine.

Thus, from the CPN standpoint, this may mean enhancement rather than retirement. We continue to face complex issues with cost overruns, physician reimbursement, physician network completion, and utilization management. It is my hope and plan to have more time for "hands on" involvement with your issues, as well as those of CPN.

So, don't be surprised in the weeks ahead if I show up on your doorstep (I'll call first!) with open ears, energized brain, and willing heart. Likewise, you may contact me through the CPN office at 303-694-2784. If you have a particular concern, remember our "two-fisted approach"; the problem in one hand - and a potential solution in the other!

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Peer Review: No matter the outcome, these words can mean financial hardship, anxiety, and the loss of countless hours for physicians and medical organizations alike.

Colorado Personalized Education for Physicians (CPEP) can help. Nationally recognized, CPEP is dedicated to helping physicians assure excellence in patient care. CPEP has assisted hundreds of physicians around the country through its program of individualized assessment and education.

Physicians, hospitals, managed care organizations and state licensing boards rely on CPEP's in-depth analysis of physicians' skills. Moreover, CPEP's customized learning plans address peer review concerns when the need for educational intervention is evident.

With increasing pressure on physicians at both the local and state level, the need for this positive alternative has never been greater.

2000 CMSA Legislative Day A Success: more counties and more physicians participated!



CMS Alliance Legislative Day Recap

The January 28, 2000, CMSA Legislative Day was a success with both more counties and more physicians than usual participating. The CMSA Legislative Day began at 8:00 A.M. with a continental breakfast outside the Old Supreme Court room where, in addition to food, there were CMSA materials and our display board to introduce legislators to the Alliance. We moved from there to the Senate gallery to hear bills being debated. The highlight of the morning was a briefing in a senate committee room where several legislators were able to be with us for a few minutes. Patti Brown, chair of the AMA Alliance Legislative Committee and a member of the CMS Council on Legislation, was also present to speak and provide handouts of legislative updates.

Lunch followed in the *Windows Room* of the Adams Mark Hotel where the featured speaker was Congressman Scott McInnis. His schedule allowed him to be with us only long enough to speak and take a few questions. This left time for an open microphone after lunch which provided an interesting opportunity for a number of people, both doctors and spouses, to make comments on legislation and the state of medicine. The comments were well taken and may be incorporated as a feature of ***Legislative Day 2001.***

A very special evening was planned to end the day. A number of Alliance members and guests attended a performance of "Swingtime Canteen," the story of a military canteen in England during World War II, at the Denver Center for the Performing Arts.

Special thanks to Lynn Painter, Phyllis VanderArk, and Patti Brown for so capably planning and presenting the CMSA Legislative Day, and to all the physicians and spouses who participated.

CMS Alliance Annual Meeting

The CMS Alliance annual meeting will be held on Thursday and Friday, April 13 and 14, 2000, at the Valley Country Club in Aurora. We are honored to have as our guest speaker Ann Hansen, the AMA Alliance president. Physicians as well as spouses are invited to put the meeting dates on their calendars and join the Alliance for all or part of the meeting. Please see the registration form in this issue.

Save This Date!!!

The date of the Metropolitan Denver Medical Society Alliance (MDMSA) Spring Dinner-Dance and Silent Auction is Saturday, April 29th, at the Columbine Country Club. Cocktails at 6:00 P.M. followed by dinner and dancing. Music by Joe Keel. Proceeds from the silent auction to benefit the the MDMSA ***"Baby Think It Over"*** project to purchase infant simulators for area high schools and for youth programs. For additional information please call Linda Culberson at (303) 798-7441 or Nancy DeLauro at (303) 757-2773.

CMSA (Colorado Medical Society Alliance)
ANNUAL MEETING REGISTRATION

April 13 - 14, 2000
Main Dining Room
Valley Country Club
14601 Country Club Drive
Aurora, Colorado 80016-1099
303-690-6373

Thursday, April 13, 2000

1:00 p.m.	General Membership Meeting
	AMAA President Ann Hansen, guest speaker:
	Setting the Tone for a Successful Year Through Team Building and Working Together Effectively
3:00 p.m.	CMSA Board meeting
6:00 p.m.	Board and general membership social time
6:30 p.m.	Board and general membership dinner
7:30 p.m.	Line dancing

Friday, April 14, 2000

8:00 a.m.	Continental breakfast
8:30 a.m.	CMSA Annual Meeting
10:30 a.m.	Break
10:45 a.m.	Ann Hansen guest speaker:
	Declaring peace on school campuses
12:00 a.m.	Lunch

Reservation deadline: April 10, 2000
Your check made out to CMSA is your reservation.
Mail to:
Maribeth Berry, CMSA Treasurer
P. O. Box 65
Wray, CO 80758

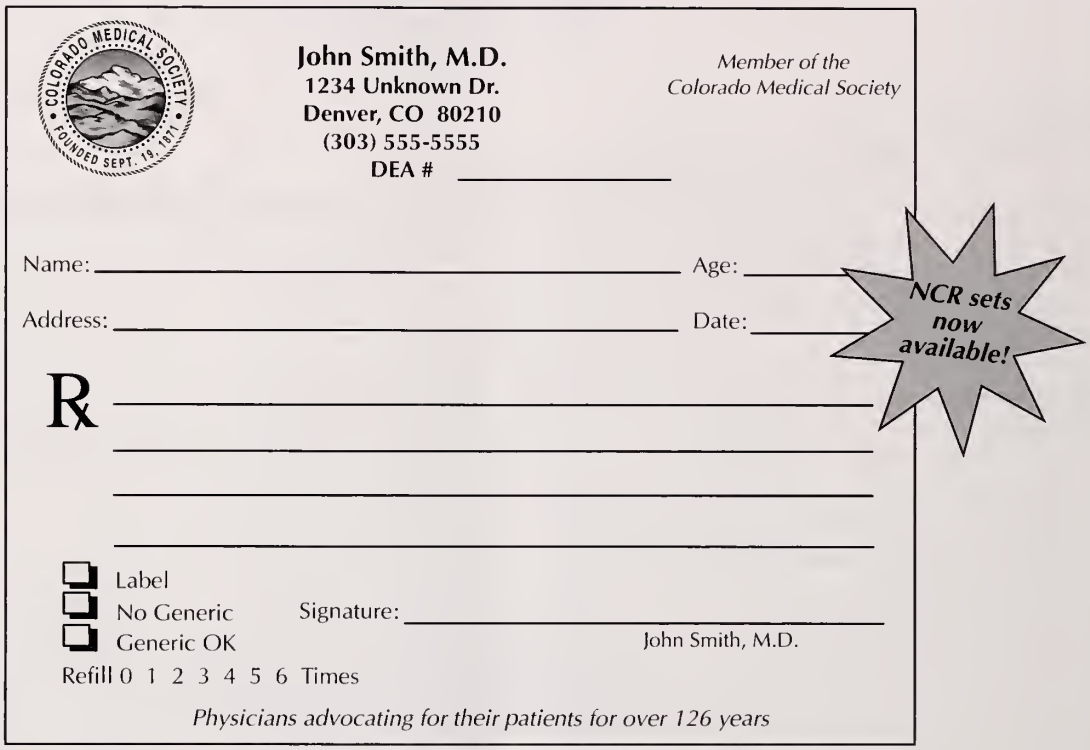
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Address _____ Phone ( ) _____

			Amount submitted
April 13, 2000 - Dinner Choice of:			
	Tournedoes of beef _____	$27.50	_____
	Salmon _____	$27.50	_____
April 14, 2000	Continental breakfast	$6.00	_____
	Lunch	$16.00	_____
	Total for all three meals - per person _____	$49.50	_____

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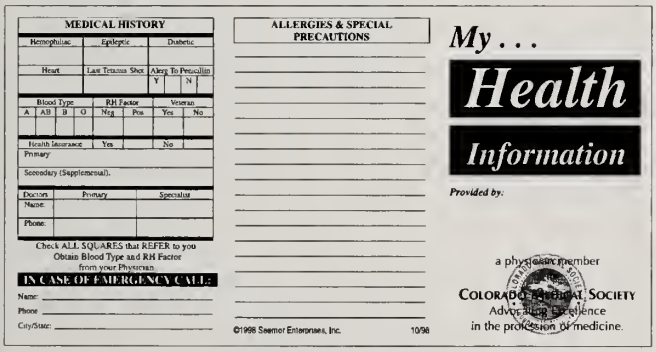
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Physicians Advocating for the patient

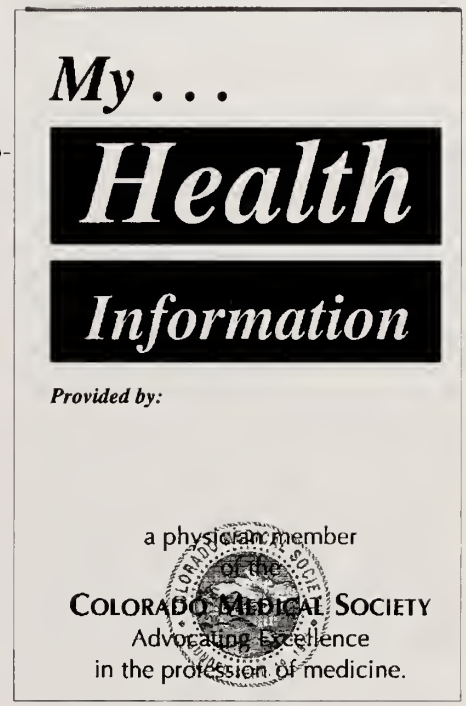
Every day we are reminded that patients of all ages do not follow their physician's directions very well. We hear of patients taking seriously conflicting substances, such as taking an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among the older citizens.

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of the medications they are prescribed, what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions.

CMS Member Services had come up with a handy device that can be supplied your patients for this very job, and at a low cost. The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as your medical needs and will hold up a long time.



1/2 of actual size



Actual size of folded card

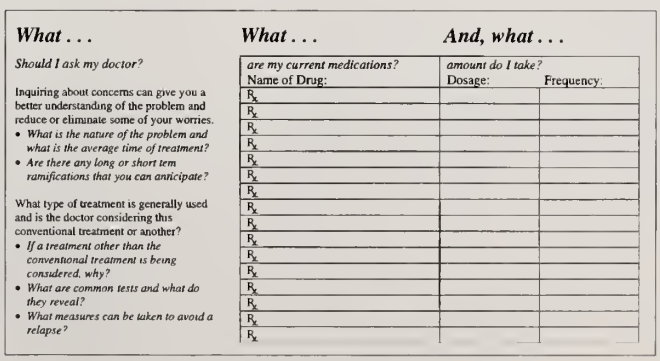
These health/medication records allow you to place a doctor identification on the front in a space 3/4" deep by 2" wide.

We at CMS feel that your patients will appreciate you for providing them with this, and will be a constant reminder of the quality of care and concern you have for their healthy well-being.

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The cards are on hand and available now from CMS. They are an exclusive CMS member service. In time, they will be widely available, but for now, CMS is the only place you'll find them.

If you wish to order, send payment in advance to CMS, Member Services, P. O. Box 17550, Denver, CO 80217-0550. Delivery will be within the week.



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BOULDER - EXCELLENT OPPORTUNITY for Board Certified MD in Urgent/Family/ Occupational care. Reply to Medical Director, Meadows Medical Center, PC 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 04/0200

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Practice Manager
StorageTek
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

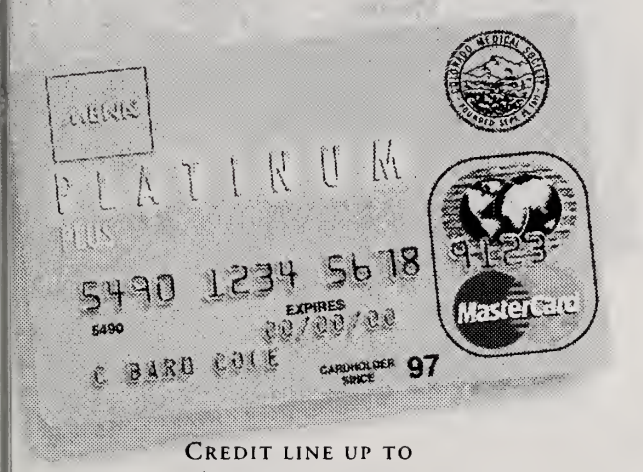
Bill Pierson
Managing Editor

A year ago I received this "Classic" piece of writing from a doctor-friend. I've asked myself over and over how I could possibly use this in a column. Finally, I made a new year's resolution for 2000: "Just do it!" I feel certain my friend wanted me to share it with you.

Answers to the age-old question, Why did the chicken cross the road?

Generic: To get to the other side.
Plato: For the greater good.
Karl Marx: It was an historical inevitability.
Tomàs de Torquemada: Give me ten minutes with the chicken and I'll find out.
Timothy Leary: Because that's the only kind of trip the Establishment would let it take.
Nietzsche: Because if you gaze too long across the Road, the Road gazes also across you.
Oliver North: National Security was at stake.
Carl Jung: The confluence of events in the cultural gestalt necessitated that individual chickens cross roads at this historical juncture, and therefore synchronicitously brought such occurrences into being.
Jean-Paul Sartre: In order to act in good faith and be true to itself, the chicken found it necessary to cross the road.
Ludwig Wittgenstein: The possibility of "crossing" was encoded into the objects "chicken" and "road," and circumstances came into being which caused the actualization of this potential occurrence.
Albert Einstein: Whether the chicken crossed the road or the road crossed the chicken depends upon your frame of reference.
Aristotle: To actualize its potential.
Buddha: If you ask this question, you deny your own chicken-nature.
Salvador Dali: The Fish.
Darwin: It was the logical next step after coming down from the trees.
Emily Dickinson: Because it could not stop for death.
Epicurus: For fun.
Ralph Waldo Emerson: It didn't cross the road; it transcended it.
Johann Friedrich von Goethe: The eternal hen-principle made it do it.
Ernest Hemingway: To die. In the rain.
Werner Heisenberg: We are not sure of which side of the road the chicken was on, but it was moving very fast.
David Hume: Out of custom and habit.
Saddam Hussein: This was an unprovoked act of rebellion and we were quite justified in dropping fifty tons of nerve gas on it.
Jack Nicholson: 'Cause it @#%&* wanted to. That's the @#%&* reason.
Pyrrho the Skeptic: What road?
The Sphinx: You tell me.
Sappho: Due to the loveliness of the hen on the other side, more fair than all of Hellas' fine armies.
Henry David Thoreau: To live deliberately . . . and suck all the marrow out of life.
Hippocrates: Because of an excess of phlegm in its pancreas.
Machiavelli: So that its subjects will view it with admiration, as a chicken which has the daring and courage to cross the road boldly, but also with fear, for who among them has the strength to contend with such a paragon of avian virtue? In such a manner is the princely chicken's dominion maintained.
McKinsey Consultant: Deregulation of the chicken's side of the road was threatening its dominant market position. The chicken was faced with significant challenges to create and develop the competencies required for the newly competitive market. McKinsey, in a partnering relationship with the client, helped the chicken by rethinking its physical distribution strategy and implementation processes. Using the Poultry Integration Mode (PIM), McKinsey helped the chicken use its skills, methodologies, knowledge, capital, and experiences to align the chicken's people, processes, and technology in support of its overall strategy within a Program Management framework. McKinsey convened adverse cross-spectrum of road analysts and best chickens along with McKinsey consultants with deep skills in the transportation industry to engage in a two-day itinerary of meetings in order to leverage their personal knowledge capital, both tacit and explicit, and to enable them to synergize with each other in order to achieve the implicit goals of delivering and successfully architecting and implementing an enterprise-wide value framework across the continuum of poultry cross-median processes. The meeting was held in a park-like setting, enabling and creating an impactful environment which was strategically based, industry-focused, and built upon a consistent, clear and unified market message and aligned with the chicken's mission, vision, and core values. This was conducive towards the creation of a total business integration solution. McKinsey helped the chicken change to become more successful.
And here's one that I would add:
Generation X: Who cares?

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Effective April 3, 2000

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Twentieth Century's Fifth Decade by John L. Lightburn, MD, Historian ..... page 129
The Hassle Factor and My Practice by Paul Kricheuvsky, MD, Lakewood, CO ..... page 135
Is There A Doctor In The House? by Susan Hellman, Seniors Counselor, Centura Insurance Co ..... page 141

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COLORADO MEDICINE

April, 2000 Volume 97, Number 4



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CMS Med Fax® is not included in this issue because of our office relocation. Please watch for it in the May issue of Colorado Medicine.

Colorado Medicine, including Med Fax®, is printed entirely on recycled paper.

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO 80230. Telephone (720) 859-1001. Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor. *http://www.cms.org/ColoradoMedicine.html*

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President's Letter



Jack L. Berry, MD
President 1999-2000
Colorado Medical Society

One of the most enjoyable aspects of the office of President of the Colorado Medical Society is the opportunity it presents to travel to the various rural areas of our beautiful state. Just this last week my wife and I were presented with such an opportunity to visit Silverton to assess medical developments in that community. Maribeth represented the Colorado Rural Health Center as a member of their board and I was representing the Colorado Medical Society Foundation, CROP (its rural outreach program) and , of course, CMS itself.

Silverton is a community of 500 winter population and about 3,000 souls during the three summer months. It is isolated by three high mountain passes in the summertime but in the winter, it is without a doubt the most isolated rural community in the contiguous United States. We were fortunate to get there as it had snowed 20 inches the 2 days before our arrival, but the snowplows had done yeoman's work and kept the passes to the south open. We were even more fortunate to get out to drive back to Denver as it snowed 12 more inches during the 18 hours we were there and Red Mountain to the north was closed long term by avalanche. The passes to the south and Durango were only intermittently open. Our difficulty in travel is probably of little interest to most but what I am trying to impart is the physical isolation of this place and the difficulty its inhabitants encounter in obtaining access to even basic medical care.

It has been ten years since Silverton and San Juan County have had a physician in residence. A physician's assistant has served the medical needs of this community; supervising physicians collaboratively have been separated from the P.A. by 50 and/or 60 miles. At times her only access to them is by satellite telephone. When it snows heavily here, no transportation, air or ground, is available. The good people of this town, a fair number of whom we met, said, "When a medical emergency arises, we all work together to keep the patient alive until we can get them to help." For a moment stand in these peoples' shoes. A broad spectrum of people chose to live in this gorgeous mountain valley and they love it there. Should they by this choice suffer limited access to even basic health care? There should be a better way and interestingly even in this tiny town there may be.

"CROP has been asked to help facilitate establishment of this program financially. . ."

The town administrator and other leaders in Silverton have worked long and hard to assist the P.A. in her work and done all they could to improve their facilities and her working conditions. They have also done their best to create an environment that would be positive for a physician. My impression of the town administrator was in fact little short of awe considering all he has been able to accomplish in many arenas in a difficult economic environment. Mining is virtually gone and the economic base is very narrow (tourism, education, a bit of medicine and general services) so

"in the winter, it is without a doubt the most isolated rural community in the contiguous United States. "

(Continued on following page)

public resources are very limited.

The good news is a physician has moved to town as it fits her needs socially and environmentally. She would like to work half time and is requesting a very modest compensation for the privilege of serving the people in this isolated valley. CROP has been asked to help facilitate establishment of this program financially and the Rural Health Center is working to help with badly needed equipment upgrades. We needed to see that this is a doable enterprise, that the physician fit by training and experience and that the community is committed to working collaboratively with the physician. Happily the answer is yes to all of these. There is the realistic hope of bringing upgraded and consistent medical care to the fine people of San Juan County and the few grouches that live there, as well.

Silverton is an extreme example of isolation and difficulty in provision of access to health care in the rural environment. I assure you there are many other very similar situations in the rural areas across our state, in the mountains and on the plains. Your medical society has gained statewide credibility and positive exposure from its work in rural medicine.

It is a matter of pride and gratification, as well, that the Colorado Medical Society has stepped up to commit itself through its foundation and CROP to work to bring better access to care to all the people of Colorado. No longer do the academic institutions or the organized societies of Colorado medicine look away from and ignore the problems of rural medicine. We have a long way to go to solve all these problems but we are, via extraordinary effort by our society, on the right road. Please let us know how you individually can assist in these efforts to provide equitable access to care for rural medically underserved Coloradans.

CPHP

Colorado Physician Health Program

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The Colorado Physician Health Program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.



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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

I can't update you on something that is just happening as you read this.

I can tell you that my feelings for any kind of a move have not changed sine the last time I moved, either home or office. There are so many things you simply have to get rid of, which necessitate tough choices.

What do you save ? What do you toss? Will you forget something that today seems vital to your every day life? Dare you leave anything for the trash? Should these papers and letters be shredded or are they safe to go into the trash or recyclable paper bin? Can you bear the thought of anything you considered so important to be caught on a chance wind carrying it away to who knows where or whose prying eyes?

We must not stop to think about things like that. We must get this "stuff" packed up in boxes, taped closed and ready for the move. We must simply close our eyes to those boxes which were packed for the last move and then stored away when we got here and still not opened. Oh yes. . . there a few boxes that were packed for the move before that move and have not been opened. Yeah. . . here's one that goes back all the way to East 19th Avenue. Good Lord! That one hasn't been opened since 1980!

What am I doing! Frankly, I think I should just move the boxes that have not been opened from past moves, and throw away all this other stuff that hasn't been packed yet. That would save a lot of time and energy. It would go a long way in saving my sanity as well.

Let's put the kidding aside and get on with the job. Why do we mess with this collection of stuff, moving from one location to another and possibly not even knowing what we are moving? Because that's the way this type of organization works. Just because! We mustn't lose the organizational thread which has bound the membership together for lo these many years. And yet, when we sit down for a planning meeting, we tell each other "I don't want to hear anybody say, 'This is how we've always done it.'" So, here we are, moving the office "stuff" because *'this is how we've always done it.'*

Don't worry. Whatever we throw away to cut down on the moving stress and expense, we have enough organizational thread to cover the bases. In today's world, Tim Roberts (CMS Director of Membership Information Services) keeps reminding me that this is why computers were developed for business, so we could get rid of the vast storage of paper. We have an excellent computerized record of the CMS past and present. I am still torn between tossing something away from 75-100 years old even when I know it has been "digitized and downloaded to the permanent backup."

We owe it to ourselves and to Copic to get our things organized, sorted out and catalogued before taking up residence in the sparkling new quarters. We're not going to sully that in any way. We owe it to you, our members, to clean up our act. That doesn't make the move any easier.

"Moving Day - 2000. Ugh!"

Just so you know what the CMS staff has been doing with sorting, saving and stuffing, we do maintain a procedure for document storage: Records Retention Guidelines:

Association and corporate records which are kept permanently are Articles of Incorporation, Bylaws, membership records, Minutes of the meetings of the Board of Directors, Councils, Committees, Task Forces and Steering Committees, and the proceedings of the House of Delegates. Of course, we also keep financial and legal documents and proceedings permanently.

Personnel records are kept anywhere from 2 to 7 years; association publications and surveys of members are kept permanently; even photographs of members have a required record life of a 2 year minimum.

Well, there you have it: an update of what I think is currently happening . . . or about to happen.

To say the least, moving is quite an event! Don't call me; I'll call you.

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING
March 17, 2000

Copic: Dr. Jerry Buckley stated that Copic recently had their annual meeting. One of their speakers was a freshman medical student, who spoke about the physician of the future and technology. Their number of insureds is at an all time high (4600). Dr. Buckley recently attended the Physician's Insurance Association of America (PIAA) meeting, where he learned that across the country there has been a significant increase in severity and frequency of claims against physicians. He stated that thanks to the efforts of Copic's Risk Management and Colorado tort reform, Colorado has seen very little of this. They have received approval of their late bill on the Colorado Credentials Solution. Senator Mary Ellen Epps will sponsor the bill. He announced that Copic has sold the building where we currently have our offices, and the move is on schedule for the end of March. There will be an open house at the new building on April 19, 2000.

CMSA: Ms. Donna Foss stated that the CMSA annual meeting is scheduled for April 13-14.

AMA Delegation: Dr. Richert Quinn stated that the AMA will be conducting their first clinical quality improvement forum on April 28. The National Leadership Conference is March 25-28 in Miami, Florida. Drs. Quinn, Berry, Allen and Karlin are attending the conference. The AMA organization has recently undergone a rather large budget cut and has laid off close to 100 employees. The American Medical Accreditation Program (AMAP) has been suspended.

Medical Executives Group: Ms. Judie Watson stated that Ms. Sandi Maloney attended their meeting, and discussed the new building with them. Also discussed was the issue of direct membership. Ms. Pat Schultz also attended their meeting and presented the tentative agenda for the Medical Executives Retreat, sponsored yearly by Copic. We all said goodbye to Ms. Peggy Fogel, Medical Executive from Pueblo. Ms. Fogel will retire at the end of March.

Dr. Berry introduced Mr. Gene Fitzgerald of Merrill Lynch. Mr. Fitzgerald is the investment councilor for CMS. Mr. Fitzgerald presented a brief overview of the investments made for CMS over the past ten years, and a brief review of the current investment portfolio. He stated that current CMS investment policy works well for our type of organization, and he didn't feel it needed to be revised. He briefly discussed recommendations made to the Finance Committee to allow him to make changes in our investment portfolio. Discussion followed.

Dr. Kruse briefly explained the recommendations from Mr. Fitzgerald, and requested approval from the board. He also requested board approval to leave the CMS investment policy as it is currently written. A brief discussion was held.

MSC to not change the current CMS investment policy (MOB-46-A).

The next board meeting will be held on May 5, 2000 at the Sonnenalp in Vail, Colorado.

The New Location



Colorado Medical Society and Copic Companies have made the long-anticipated move to the new quarters at 7351 Lowry Boulevard in Denver. The brand-new structure holds many a hidden moving day wrinkle, none of which was not overcome by hard working staff members who coordinated the move and the consolidation of all six entities (Copic Insurance, Colorado Medical Society, The Gadrian Corporation, Copic Financial Service Group, Ltd., Practice Quality and the law offices of George Dikeou).

Everyone involved in the new CMS headquarters is certain that the many physician members who serve on the various volunteer committees, councils and task forces will enjoy the working conditions in this building. There is, first of all, ample parking space (both covered and open), easy access from all sides of the building, three elevators to travel to the various organizations, and pleasant, comfortable decor in the conference areas.

The new board room just off the main lobby is the latest state-of-the-art in acoustics and audio/video engineering. Food service is well designed and practical for those using the board room. There is ample room for seating of the board members and others. Board members and attendees will be pleased with the facility, its airy, light feeling. All is a part of the design to make these meetings more efficient and pleasant.

The main lobby is done in subtle terms, handling the old and the new. A sense of longevity is achieved by the marble or terrazzo used in the lobby and elevator area. Colors are subdued but pleasing Step into the elevators and you know you're in 21st century surroundings. The new office cubicles also offer a great deal to this up-to-date design and decor. New lighting, food handling equipment and furnishings in the building's cafeteria are evidence of consideration by the designers for staff.

There are various approaches to the building, located on the northeast corner of Lowry Boulevard and South Quebec Street.



Colorado Medical Society

2000 Leadership Conference Registration Form

May 6-7, 2000 • Sonnenalp Resort, Vail

❒ I plan to attend the Leadership Conference to be held May 6-7 at the Sonnenalp Resort in Vail, including dinner on Saturday night.

❒ My spouse/guest will attend the Conference and dinner on Saturday.

❒ My spouse/guest will not attend the Conference but will come to dinner on Saturday night.

_____ _____

Name Component Society

_____

Name of Spouse/Guest (if attending)

Mail to CMS, P O Box 17550, Denver, CO 80217 or Fax 720-859-7509

Sonnenalp Resort of Vail

Group Name: Colorado Medical Society

Name:_____ Phone #: ( ) _____

Address: _____

City: _____ State/Zip: _____

Number in Party _____ Arrival Date: _____ Departure Date:_____

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Please Note: A deposit equal to one night's stay will be charged to your credit card. Balance is due upon check-out.

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(Note: most suite types cannot accommodate more than 3 adults.)
Reservations received after April 21, 2000, will be taken on a space available basis only.
Cancellation Policy: In the event of cancellation 14 or more days prior to arrival, you will receive a full refund. If you cancel less than 14 days prior to arrival, you will forfeit the deposit of one night room and tax.
Reservations will be taken with this form or call our Reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort of Vail, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

2000 Leadership Conference

Each year, Colorado Medical Society's President-elect hosts a leadership planning conference to put forth the agenda for the coming program year. The President-elect for 2000-2001 is Dr. Richard Allen. For the 2000 Leadership Conference, Dr. Allen has chosen to work with the CMS Committee on Professional Education and Accreditation, preparing a conference with major emphasis on lifelong learning.

Medicine in the Next Millennium: A Return To Professionalism

The conference will be held May 6-7, 2000, at the Sonnenalp Resort, Vail, Colorado. All CMS members are invited to attend.

Focus of the conference is to "reinvigorate professionalism and physician pride." To accomplish this end, the program revolves, in a very upbeat fashion, around the future of medicine while stressing the fundamental need for lifelong learning.

Two areas are being further emphasized: Education of the physician, and Genetics. The objective of the latter portion of the conference is to expedite and incorporate the appropriate new findings into clinical practice, especially in relation to advances in genetics research. Genetics is being used as a current example of the need for physicians to realize that the science and technology of the future is now.

Saturday's schedule begins with a presentation on Medical Professionaism by Dr. Matthew Wynia from the Institute for Ethics. This will be followed by panel presentations (15 minutes each) and discussion (45 minutes) from Dr. Richard Krugman, Dean of the University of Colorado School of Medicine (medical education); Drs. Harry Jonas and Frank Simon (Division of Graduate medical Education), Dr. Vincent Fulginiti (medical education in academic health center). In this portion, the emphasis is placed on the future and the need for lifelong learning, ethics, and professionalism. This program seeks to incorporate the topic of "mentoring" medical students and residents as a responsibility, an avenue for passing along the legacy, and a means for modeling professionalism.

Saturday afternoon is free for reflection, recreating and/or spending time with the speakers. There will be a dinner Saturday evening followed by a special presentation by Dr. Jonas which everyone, including spouses, will enjoy.

Sunday morning's program, May 7th, will deal with genetics, preceded by a presentation of futurist Jeffery Bauer, PhD.

Following Dr. Bauer, Dr. Richard Spritz will give attendees an overall picture of what is occurring in genetics research. A panel will discuss ethical considerations, dilemmas encountered in practice and indications of continuing education to meet the needs of this new medical research.

The Sonnenalp Resort of Vail has been a highly successful venue for the Leadership Conference for a number of years.

The future's plan

In CMS' 2000-2001 program year, President-elect Dr. Allen wants to see a "return to professionalism" which has highlighted medical practice for many decades.

Dr. Allen says, "I see this being stymied and eroded away in all aspects of medical practice and academic medicine. There are ways in which renewal of professionalism can be attained, but it must come from within."

Dr. Allen added that "an integral part of the quality of medical practice is lifelong learning by physicians. We hope to focus our efforts in the coming year on these aspects of the practitioner's life."

On an accompanying page you will find registration details for the conference and a reservation form for the Sonnenalp.
For further information, contact:
Lorraine Heth, Program Mgr.
(720) 859-1001 or
Lorraine_Heth@cms.org

2000 Leadership Conference • Colorado Medical Society
May 6-7, 2000 • Sonnenalp Resort • Vail, Colorado

Schedule

Saturday, May 6

9:00 a.m. – 9:05 a.m.	Welcome and Introduction, Richard Allen, MD
9:05 a.m. – 10:00 a.m.	Matthew K. Wynia, MD, MPH Section Director for Managed Care, Institute for Ethics "Medical Professionalism"
10:00 a.m. – 10:15 a.m.	Discussion/Question and Answer
10:15 a.m. – 10:30 a.m.	Break
10:30 a.m. – 12:30 p.m.	Panel: Life Long Learning: Professionalism in Action Richard Allen, MD, Facilitator
10:30 a.m. – 10:45 a.m.	Richard Krugman, MD, Dean Univ. of Colorado School of Medicine Medical Education: Colorado Perspective
10:45 a.m. – 11:00 a.m.	Vincent Fulginiti, MD Medical Education in Academic Health Centers
11:00 a.m. – 11:15 a.m	Harry Jonas, MD Medical Education: National Perspective
11:15 a.m. – 11:30 am.	Frank Simon, MD Graduate Medical Education
11:30 a.m. – 11:45 a.m.	Richard F. Bakemeier, MD Continuing Medical Education
11:45 a.m. – 12:30 p.m.	Discussion with Audience

Sunday, May 7

9:00 a.m. – 9:05 a.m.	Welcome and Introduction, Richard Allen, MD
9:05 a.m. – 10:00 a.m.	Jeffrey C. Bauer, PhD The Science and Technology of Medicine: The Future is Now
10:00 a.m. – 11:00 a.m.	Richard Spritz, MD Current and Future Applications of Genetics Research
11:00 a.m. – 11:15 a.m.	Break
11:15 a.m. – 12:30 p.m.	Panel Discussion: Dr. Richard Spritz, facilitator Patent Issues: Ellen P. Winner, Esq. Ethical Issues: Charles Scoggin, MD Practical Genetics: David Manchester, MD



by John L. Lightburn, MD
Historian
Colorado Medical Society

The Twentieth Century's Fifth Decade

> "How can the magnificent discoveries of science be put to the most efficient and most desirable human uses? . . . Among physicians, recognition of the challenge led to searches for all answers. After all, doctors from time immemorial had
> come into the closest contact with humanity and its needs."
>
> *Charles Beard, American Historian*

In the October and November, 1998 issues of this joumal, the impact of World War II, 1941-45, was briefly described. I would like to visit that era again and focus on the response of some of the presidents of Colorado Medical Society. Continuing with the CMS presidential vignettes, let us first visit William H. Halley, our 70th President.

This Denver surgeon was admired by many for his dedication to his patients, his profession and the state medical society. After receiving his MD in 1907, he practiced briefly in Kansas City and then moved to New Mexico, then Trinidad and finally Pueblo. After a few years in general practice, he completed a year of graduate studies in surgery at Harvard. He left Pueblo to enlist in the Army in 1917. After the war, he moved to Denver.

From the early 1920s, he became active in the local and state medical societies. His political savvy and foresight established him as the "king maker" in CMS. Several CMS milestones are monuments to his leadership. Among these were his efforts in bringing a full-time executive secretary to the society, in passage of Colorado's Basic Science Law, in the defeat of the Chiropractor-sponsored constitutional amendment in 1938 (a plan to circumvent the Basic Science Law) and in the expansion of the CMS in 1946.

Late in his presidency, he suffered a myocardial irrfarction which kept him away from the 1941 Annual Session. But he soon was back in the thick of society business and in 1946 was elected to the first of four terms as delegate to the AMA. His energy and understanding of the issues brought hirn national recognition. Under his leadership, Colorado



William H. Halley, MD

was known as one of the "big three" states along with California and Michigan in the AMA House of Delegates. Those three states with Bill Halley's pressure created a modern AMA public relations program which ended the 20 year reign of one man as the sole AMA spokesman*. The "big three" also reinstated the House as the "boss" and not the servant of the Board of Trustees.

In Dr. Halley's presidential address delivered in Colorado Springs on September 12, 1940, there was less strident rhetoric about "socialized medicine" and a more moderate tone of hope that with creative and innovative plans, organized medicine could effectively respond to the "powerful movement of thought and energies headed in the direction of social medicine." To support this idea, he pointed to the growth and accomplishments of the CMS which in 1940 had 1250 members. He was pleased with the progress of the Colorado Foundation which, after four years, had assets exceeding $11,000, an impressive sum during those bleak depression years. This foundation was the first of at least three foundations created by the CMS.

As an example of an innovative response to the threat of national health insurance, he urged the State and local societies to develop programs for providing medical care to low income patients. A special committee and the Committee on Economics had developed a plan for a statewide prepayment plan for low income groups and called it the Colorado Medical Service, Inc. (the forerunner of Colorado Blue Shield). He acknowledged that many physicians were opposed to any kind of insurance that would come between the doctor and the patient. He asked all physicians to receive the plans with "your tolerant and mature cnsideration."

In anticipation of possible U.S. involvement in the European war, a

(Continued)

Committee on Medical Preparedness had been organized by the AMA and John Amesse was Colorado's representative. In addition, Dr. Halley encouraged local societies to initiate measures to protect those members who will be called into military service.

Dr. Halley maintained an actjve interest in medical science and published numerous papers reflecting his investigative activities. One paper, "The use of Thymophysin in Labor," exemplifies his work and the state of obstetrics in 1931.
This preparation was "a combination of extracts of the thymus and posterior pituitary and was alleged to be useful in the early stages of labor to facilitate dilatation as well as in the second stage to expedite delivery; a reliable oxytoxic." After discussing the pharmacology of oxytoxics, he presented brief summaries of 60 cases where this substance was used. His conclusions were not reassuring; 1. The action of Thymophysin is identical with that of other posterior pituitary extracts.
2. Very strong to tetany-like contractions may result. Thymophysin has all the dangers of posterior ptuitary extracts. 4. It does not add anything of value to obstetric practice. 5. favorable comment in the literature may lead the practitioner to believe that thymophysin is safer than other pituitary extracts." And Dr. Halley wanted his colleagues to know the truth about this preparation.

In paying tribute to Dr. Halley, the CMS Board of Trustees later said "On occasion, Dr. Halley's pen and speech alike could be charged with acid when deep etching was needed, but when cutting into the center of a problem his actions and words always bespoke a kindly and understanding tolerance."

Guy C. Cary eas our 71st President. An ophthalmologist from Grand Junction, he was a man of many talents and interests. After high school in Aurora, Illinois, he went to work for the railroad and was still a proud member of the Brotherhood of Railroad Trainmen years later when he came to Colorado. He left railroading to join his grandfather who was a wood carver. Next he was an electricical engineer with a degree from the University of Illinois. A year later, he returned to the same school to study medicine. (It takes a while for some of us to make up our minds.) A year later he contracted pulmonary tuberculosis and came to Colorado to recover. He resumed his education, this time at the University of Cdorado.
A year's internship at the old Denver County Hospital and a year's postgraduate study at the Wills Eye Hospital in Philadelphia followed his MD degree in 1913. He practiced in Boulder until 1917 when he was called to Denver as an Army Aviation medical examiner. In late 1918, he moved to Grand Junction. He was a deeply religious man and quite outspoken about unethical or shady behavior by his colleagues, hospital staff and politicians. He was known in the 1950s as the toughest member on the CMS grievance committee. Nevertheless, he was asked to serve on that committee for many years.

Dr. Cary's presidential address was a scholarly lecture on the history



Guy C. Cary, MD

and practice of aviation medicine. This was indeed a timely subject, but why did he limit his address to a scientific treatise in aviation medicine with not one word about the issues facing organized medicine? I wonder if this moral church going and patriotic man who loved aviation and flying had tried to enlist in the Army Air Corps and could nat meet the physical requirements. The greatest air force in the world and he could not get in. So maybe while he was telling his colleagues about the dangers and stress of flying, he was telling himself, "Face it, Guy, flying is too much for you." Whatever the reason, his address was different and special.

The House of Delegates decided to reach out to the rural physicians of the state and elected Ralph S. Johnston from La Junta as our 72nd president.

The nation was deep in World War II and over 20% Of the physi-



Ralph S. Johnston, MD

cians in Colorado were now in the armed senrices. Those remaining were busier than they had ever been. It is not clear why Dr. Johnston had accepted the presidency; he certainly viewed the office differently than any of his predecessors. He declared himself too busy to attend the meetings of the Board of Trustees or important committees, too busy to answer letters from officers of the AMA. By telephone, he directed the Vice-president to make all presidential committee appointments. Medicial mail sent to him was returned to Denver unopened. One wonders how the CMS survived with the Executive Secretary, Harvey Sethman, away in the armed service and a president unavailable.

Dr. Johnston's presidential address was the briefest on record. In the address, he said, "We have a threefold responsibility: first, to maintain our own health; second, to maintain the health of the commu-

nity in which we live; and third, to bolster the morale of every individual with whom we come in contact." He discussed these three tasks for ten minutes and ended his talk with, "We must not fail; we are winning this war at home."

After receiving his MD at Rush Medical College and completing his



George P. Lingenfelter, MD

internship at Kansas City General Hospital, he came to La Junta in 1913 to become house surgeon at the Santa Fe Railroad Hospital. In 1919, he became Surgeon in Charge. He was a successful surgeon and was a Fellow of the American Cdlege of Surgeons. In spite of these credentials, he was a stubborn man and until the mid 1930s he did not use gloves or a mask when operating. "If you scrub well enough and don't sneeze, this is alright." Finally, when he was warned that he would be liable for a malpractice suit: if he continued to neglect modern asepsis. His family seldom saw him; he was at the hospital from dawn to dusk, and after a quick supper, spent several hours every night on house calls. I hope most of us no longer follow that sort of schedule.

Now to our 73rd president. Throughout 66 years of practice, Dr. George P. Lingenfelter's patients loved him. He was the nation's senior dermatologist when he retired at the age of 90. It is amazing that he found time to be the 73rd president of CMS. Dr. Lingenfelter was 70 when he gave his presidential address.

He was graduated from the University of Missouri medical college in 1897 and was a contract surgeon in the Missouri Volunteers in the Spanish American War in 1898. After a brief general practice in Excelsior Springs, Missouri, he moved to Denver in 1902. Following a year of graduate study in dermatology at Massachusetts General Hospital and another year in Berlin, Paris and London, he returned to Denver to practice dermatology and syphilology. He joined the faculty of the University of Colorado.

In 1943, that man from New York, Senator Wagner, had introduced Senate Bill 1161 to provide universal compulsory health insurance paid for by a payroll tax of 6% with an additional 6% paid by the employer. George Lingenfelter was enraged, and he gave vent to his rage in his presidential address. "May I be pardoned for presenting at once what seems to me to be the most imminent danger to the freedom and action of American Medicine. No Informed and thoughtful individual can fail to recognize the threat to medical progress and to Public Health in some of the proposed legislation in Washington." He devoted the entire address to the dangers of "socialized medicine". But do not think this man lacked concern for the public. For twenty years, he directed Denver's Steele Isolation Hospital. There, he developed an ultra-violet ray method of sterilizing the mucosa of diphtheria carriers. There he also led the total population vaccination efforts during the 1920-21 smallpox epidemic.

Nearing 94, he was again donning his tuxedo for a country club dinner when he lay back on his bed and slept away with a cardiac arrest.

Although the Great Depression deprived us financially, and the war demanded many sacrifices, I thought we were kinder, more open, more neighborly and more generous than we are today in these affluent times. What has peace and prosperity done for us, or to us?

* Who was the "spokesman" who was displaced by Bill Halley and his fellow delegates? If you know, send in his name to Bill Pierson, CMS. The first person to send in the correct name will be awarded a one year membership in the Colorado Historical Society.

NOTE: We will accept only entries sent by U. S. Postal Service. The entries will be judged by the date of the postmark.

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PEPP Effort Focuses on Medicare Payment Education

by Richard G. Kessel, Ph.D., Lucia M. Hammer, RN, BSN, Carmen Moore
Colorado Foundation for Medical Care

". . . the area most begging for improvement is documentation problems among Medicare providers."

Donna E. Shalala, Secretary
Health and Human Services

By now many people within medical circles have heard of the Health Care Financing Administration's (HCFA's) Payment Error Prevention Program (PEPP). Unfortunately, PEPP's ominous name has given many the wrong impression. The initiative grew out of a study that found $12.6 billion in improper payments during fiscal year 1998. One-quarter of these payments were made to acute care facilities. Recently released figures indicate a statistically insignificant increase in inappropriate payments to approximately $13.5 billion in 1999. It is estimated that 7.97% of all Medicare claims in 1999 were inappropriate.

While much media attention has focused on the fight against fraud and abuse within the Medicare program, HCFA has recognized that the majority of inpatient payment errors are due to human error brought about by a complex system. The PEPP program is charged with implementing systems and educational programs to reduce the number of these errors. The focus of the program is education, not punishment. While numerous agencies are pursuing criminal activities, CFMC's PEPP activities are designed to assist Colorado providers.

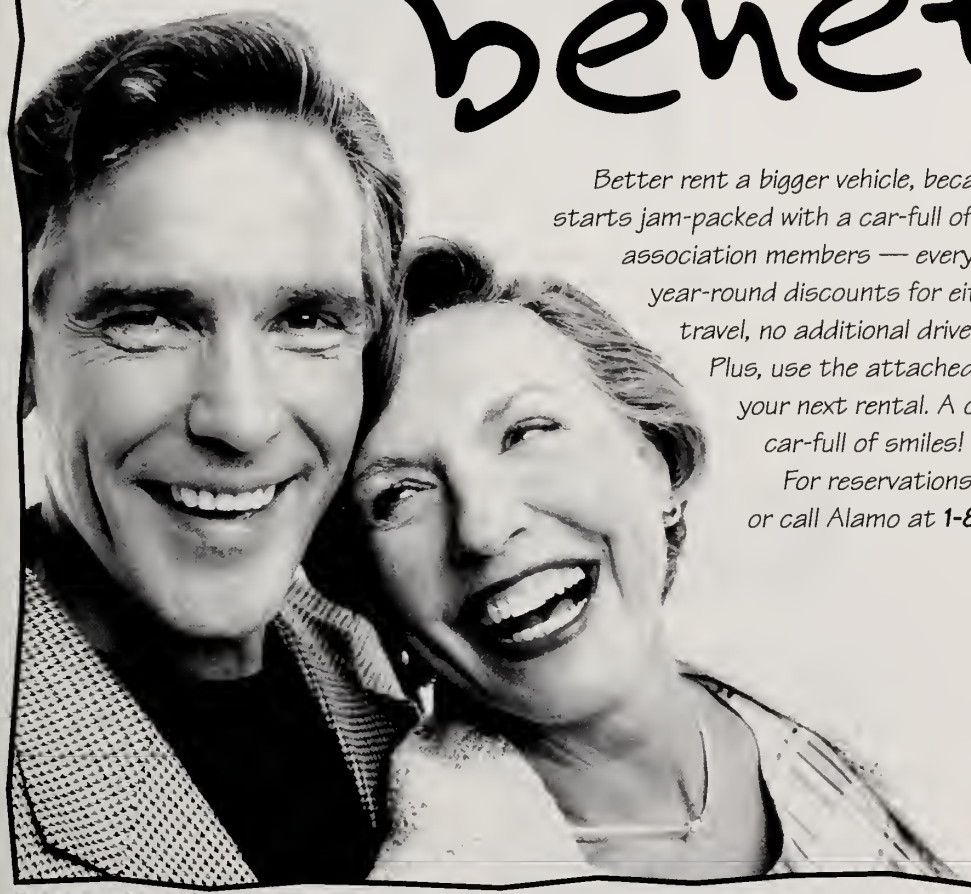
HCFA is currently in the process of reviewing 1,100 randomly selected Medicare records to determine Colorado's baseline error rate. CFMC's goal is to reduce this rate 10% by mid-year and 50% by the summer of 2002. To reach these ambitious goals, CFMC has begun collecting its own data in order to better focus its efforts. Initial results have indicated several system limitations and have also identified the need for clearer, more timely physician documentation.

Our current activities are focused on improperly coded diagnosis related groups (DRGs) and short stays. Both investigations are looking to identify clinical scenarios which require additional communication between coding and clinical staff. For example, we have found that DRGs 144 and 475, "Other circulatory diagnoses with complications and comorbidities" and "Respiratory system diagnosis with ventilator support" respectively, are especially difficult to code without clear and specific documentation.

Neither HCFA nor CFMC are drawing conclusions about an individual physician's or facility's clinical judgement. The only expectation of physicians is that they legibly and completely document patient care. Speaking to attendees of the recent Health Care Compliance Association conference, Health and Human Services Secretary Donna E. Shalala noted that "the area most begging for improvement is documentation problems among Medicare providers." Experts agree, unambiguous documentation increases coding accuracy while aiding physicians in the organization of their thoughts. The quality of care is enhanced as well. If you document as if you assume the covering physician will have to tend to your patient, you will find that your assessments are enhanced, you will complete diagnostics on a more timely basis, and you will reduce the likelihood of overlooking an aspect of care.

To assist CFMC with this program we have brought together the expertise of our Medical and Associate Medical Directors, RNs, coding specialists, biostatisticians, health educators, and communication professionals. We have also convened an expert panel to provide guidance. Representatives from the Colorado Medical Society, Copic Insurance, the Office of Inspector General, Colorado Health and Hospital Association are just a few of the members. Notably absent from the panel are practicing physicians. If you would like to participate and share your experiences, please contact Carmen Moore at (303) 695-3300, ext. 3132 or copro.cmoore@sdps.org.

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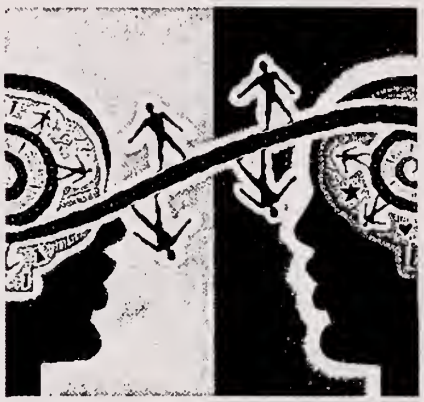
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Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health Program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

The Hassle factor

It's getting to be a hassle. I hear that every day and I say something like it every day. Scheduling an appointment requires a phone, someone to take the call and schedule the appointment, to get the chart when the patient shows up, get a routing slip, put them in a room and let the doctor know.

The doctor sees the patient, makes notes regarding the problem, the signs, the observable abnormalities, the diagnosis and the treatment. If a shot is ordered the immunization record has to be filled out. If a prescription is required the physician must write add explain the reason for the prescription, explain the side effects and check with the insurance company formulary to see if the substance is allowed. He also records the prescription, checks the routing slip and signs his notes. The aide writes the immunization in the proper immunization sheet and notes the number of the batch which the prescription was taken from. A drug prescription is also recorded on the medication sheet. The charge is made and the chart re-filed.

If a patient or pharmacy calls, the chart is obtained and proper notes made regarding the reasons and outcomes. If the formulary prescription is not allowed for some reason, a new prescription and the proper recordings are made. The chart is re-filed.

The routing slip goes to billing and the patient and insurance companies are billed through the computer and the mail. When the bill is paid by the insurance company, the proper amount is entered in the billing slip and the patient charged the balance or it written off for various reasons.

Records are kept of the charges and moneys received and forwarded to a bookkeeper who keeps track for the government and to make sure insurance companies are paying the correct amount for the correct service and to make sure the account is viable. If the patient is concerned about the bill, the accounting clerk is required to explain it and, if necessary, correct it. When payment is received, someone must note it and the corrected statement forwarded by mail to the patient.

Twenty times a year I am required to prove to insurance companies and hospitals that I am still a graduate of the same medical school, that my health is unchanged and that I am of sound mind and body. The insurance companies charge me for this service.

The rent is increasing and wages are escalating. Drug and equipment costs are rising. Reimbursements are declining. Patients are better informed and come in with information from the internet and various other sources to demand or request expensive drugs (tests, therapy, supplies). Insurance companies require that I follow a formulary which is changed frequently and formularies differ for different companies. Drug representatives inform me why their products are different from competitors and therefore better. Insurance companies flood me with requests for free information on patients. My records are frequently inspected by companies who tell me how I can or must change my charts to meet their requirements. Reimbursements will further decline unless I comply.

I have to see more patients per day so I can make ends meet.

I love what I do but it's getting to be a hassle.

Paul Kricheuvsky, MD
Lakewood, CO

LETTERS

Colorado Medicine
To the Editor:

After reading the component society news, "Physicians and PacifiCare Face Off" (Colorado Medicine, Vol. 97, No. 3), I had a hard time believing that neither the leaders of the Denver Medical Society nor Val Dean of PacifiCare expressed an understanding of the macroeconomics of health care and the contractual relationship as it relates to risk.

Perhaps they were defining "risk" as a term of art, or narrowly as in "at risk" contract. But until physicians understand by signing a contract to provide care, under all circumstances, they are at risk, there will be no paradigm shift, no new model.

As a contractor, there are obligations imposed by the contract. If the physician, as a contractor, does not perform under the contract, as in any other contract, there will be repercussions up to and including penalties and non renewal. Specifically, PacifiCare has a premium of $150.00 (approx.) per member per month. That premium is budgeted for administration, marketing, medical management, hospital costs, professional fees, pharmacy and ancillary services. If the physician overspends (the physician has some control in costs related to hospital, professional fees, pharmacy, ancillary services) PacifiCare will apply withholds, decline to renew the physician's contract, or fund the pools with less money in subsequent years to make up the deficit. Physicians complain about decreasing compensation, but until they learn to control costs, compensation will continue to decline. It is not necessarily low premiums that are responsible for lower compensation. PacifiCare cannot raise the premiums high enough to offset uncontrolled spending.

The value of a medical organization (IPA, medical group) is not to get all they can from the HMO, but to work together to control costs and maintain quality, An individual physician cannot institute demand management, disease management guidelines and identify best practices. PacifiCare has initiated some of these programs, but physicians have not responded as if it came from peers at a local level and the incentives were aligned. In summary, there is a limited amount of money to be spent on healthcare. Physicians that exceed the budget will face consequences. The individual physician has little chance of controlling costs. Groups of physicians must work on a local level to control costs by improving the way they practice, such as evidence based medicine, and eliminating waste, such as unnecessary medical care, and maintain quality. This should bring them better compensation for the work they perform.

William J. Mandell, DO
Colorado Springs, CO

El Paso Foundation Grants in the Community

The El Paso County Physicians Foundation has set their 2000 grant application deadline for April 30, 2000. The Physicians Foundation is a nonprofit foundation which is "dedicated to the enhancement of the health and well-being of the citizens" of the community by supporting and empowering other nonprofit organizations in achieving their own missions.

Grants do not exceed $3,000.00 and applicants must request funds for a specific project, program or need which can be specifically advanced by the award, be active in the area of human services, and in the geographic area known as the "Pikes Peak Region".

G. Thomas Morgan, MD, President of the Foundation Board, was one of the founders of the Foundation in 1992. In a recent article in the *American Medical News (AM News),* Dr. Morgan said "I had a patient come to me back in 1991, and he was quite upset with health care and doctors in general." Dr. Morgan added, "He made the comment, 'You doctors are takers; you don't give anything back to the community.' I was part of a committee that had organized physicians to cover high school football games, and there were 30 docs that were standing on the sidelines every Friday night. We volunteer at community health centers and we sit on all sorts of boards. So I was pretty frustrated by that comment."

Dr. Morgan went to the board of directors of the El Paso County Medical Society and asked that the society consider doing something that had an impact on the health of the community but also would bring public attention to the good community deeds that doctors perform

Since 1992 the foundation has given out more than $120,000 to a variety of programs, ranging from Mothers Against Drunk Drivers to the Children's Museum of Colorado Springs.

While the exact number of foundations established and run by organized medicine is not known, experts said they run the gamut form those that may have been set up by patients of a specific physician and have narrow funding guidelines to those, like El Paso, that receive grant proposals and give out funding to a variety or organizations annually.

Dr. Morgan added, "We are trying to work more one-on-one with individual physicians or small group practices to try to get our message out. Many of our foundation board members rub shoulders with people in the hallways of our hospitals, and we are constantly reminding them of the advantages of giving to our foundation versus another organization. Our board is going to be more active as individuals, and we are going to have a more organized game plan for approaching people."

Dr. Morgan told *AM News* he hopes to achieve an initial endowment of $50,000 to $60,000 that can grow in time to $5 million.

CMS Foundation a Colorado Success Story

Much like the El Paso County Medical Society's foundation, the Colorado Medical Society recognized the need to create just such a vehicle when attempts to move the Colorado State legislature failed. The need was to bring health care to individuals anywhere in the state, with particular emphasis on Colorado's rural areas. As a result, the CMS Board of Directors created the program, "CROP " (Colorado Rural Outreach Program), which then grew into the CMS Foundation. Through grants, the organization has recently fulfilled the medical equipment needs of a number of Colorado rural clinics, and awarded grants to physicians entering rural practice and helping them to pay back their medical school loans. The CMS Foundation now serves as an umbrella organization which can enable individual' who wish to bequeath or to make outright monetary gifts to these kinds of programs. The CMS Foundation continues to operate the CROP program and to provide a substantial contribution to the Colorado Coalition for the Medically Underserved.

Physician members of Colorado Medical Society have, thus far, contributed over $200,000, but fund-raising must continue. We don't hesitate to remind you that you can still make a gift to the CMS Foundation from anywhere, and the funds will be put to good use for good health.

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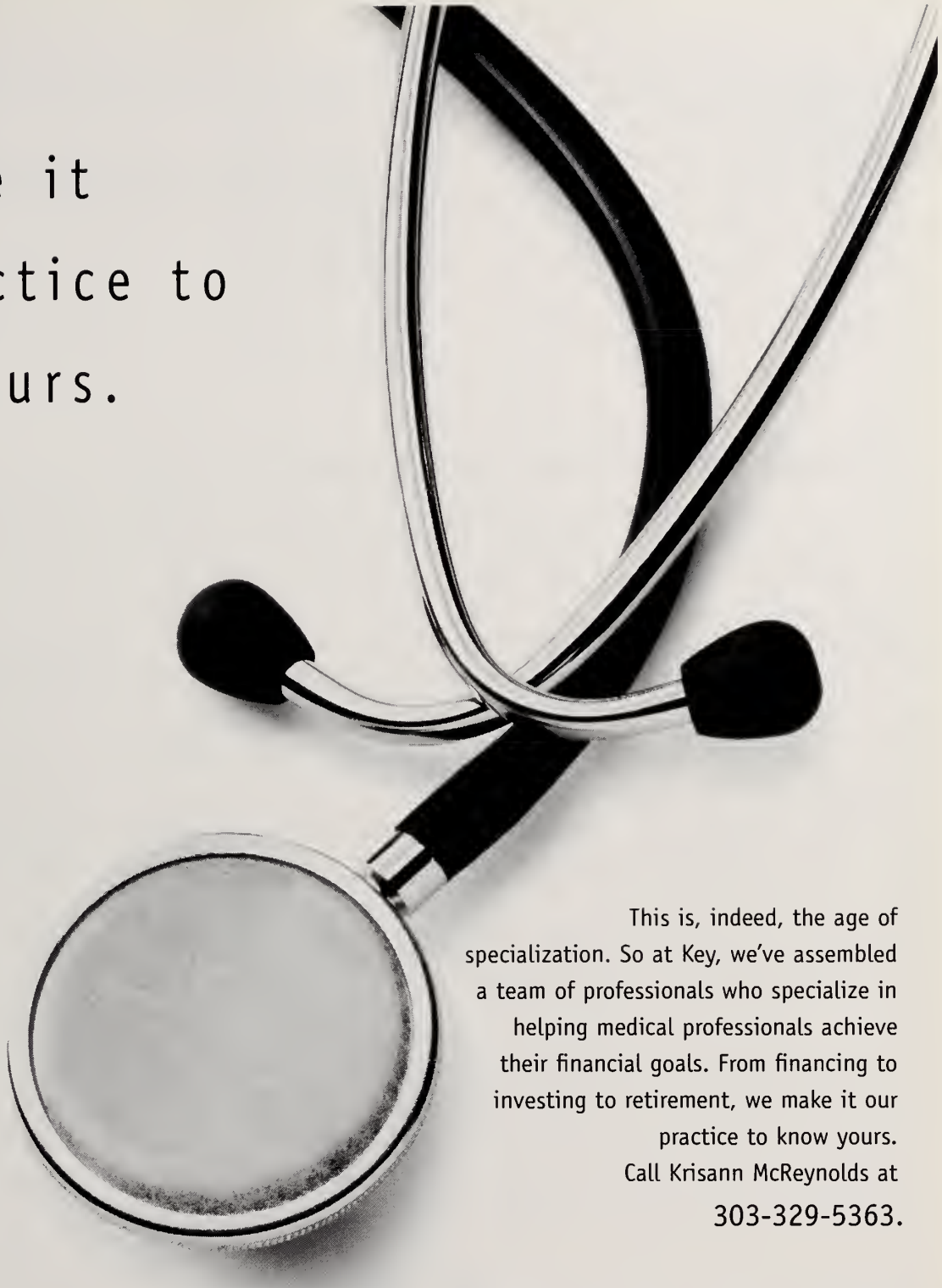
From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovate solutions to complex dilemmas.

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2. Be recognized for outstanding community service, separate and apart form his/her medical service or activities.

We wish to honor the physician judged by his/her colleagues to have contributed most significantly to civic activities and the community good. All nominations must be accompanied by documentation of the physician's community services; i.e., testimonials from community leaders, honors and awards received by the nominee for outstanding community projects, testimonials from peers, friends and associates.

Address all nominations to:
Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550

Nominations must be received by Midnight, July 31, 2000, to be considered. The award will be presented at the CMS Annual Meeting in September, 2000, at the St. Regis Hotel in Aspen, CO.

Is There A Doctor in the House?

by Susan Hellman, MA
Centura Health Insurance Counseling for Seniors

Moments ago I hung up the phone after talking with a 68-year old Colorado resident. He called to say his doctor of fifteen years stopped accepting Medicare patients effective March 1, 2000 and the caller could not find a replacement. As director of Centura Health Insurance Counseling for Seniors in Denver, I'm afraid I could offer him few remedies, other than to open the phone book and start making inquiries. Five years ago, our counseling office rarely received calls concerning physician access. That is no longer the case. On a daily basis our office fields calls from seniors desperately searching for internal medicine or family practice physicians who will care for them. The problem seems to be worse along the front range, especially in Denver and Colorado Springs.

There seem to be two problems. The more pressing is the inability of patients with original, fee-for-service Medicare to find primary care. The other is the difficulty that Medicare HMO members have selecting a primary care physician from the lists supplied by their HMO. Often these lists are not up-to-date, do not provide a lot of choices, or require elderly people to travel farther than they are able.

Individuals who remain on original Medicare with its inherent freedom to select providers at will may have excellent secondary coverage to back up their Medicare in the form of employee retirement packages or Medicare supplemental insurance. Yet they are increasingly faced with practitioners who will no longer see any Medicare patients or who require these patients to enroll in a specific Medicare HMO. Patients compelled to enroll in an HMO in this manner may have to relinquish supplemental or retirement coverage, and in some cases may not be able to reapply for these policies.

I am more than sympathetic to the physicians' frustrations with obfuscated claim filing rules, inconsistent fee schedules, tedious interactions with management companies for referrals, infuriatingly slow payments, as well as fraud and abuse concerns. I am also aware that taking care of seniors is more time-consuming than caring for younger populations.

Perhaps the Colorado Medical Society wishes to develop a coherent statement from its physician members informing the public of their position on this issue. In the meantime I propose that any physician in Colorado whose practice is open to "original" Medicare patients contact CMS so that counseling offices can pass on this information to consumers.

Susan Hellman, MA, is director of Centura Health Insurance Counseling for Seniors which provides free counseling about Medicare and Medicaid. 1-800-544-9181

1601 Lowell Blvd.
Denver, CO 80204
303-899-5151 or 1-800-544-9181

". . . the inability of patients with original, fee-for-service Medicare to find primary care."

COLORADO FOUNDATION FOR MEDICAL CARE

Address: P. O. Box 17300 • Denver, Colorado 80217-0300 • http://www.cfmc.org

Location: 2851 So. Parker Road • Suite 200 • Aurora, Colorado 80014-2713

Phone: (303) 695-3300 FAX: (303) 695-3350 TDD: (303) 695-3314

OPEN LETTER TO ALL COLORADO DOCTORS

from the Colorado Foundation for Medical Care (CFMC)
Regarding Need for Physician Review Services

Dear Colleague:

Undoubtedly, you have heard about Federal programs to weed out fraud and abuse in Medicare billing, CFMC has been given the task in Colorado of determining if problems exist in health care facilities. We are not responsible for evaluations of doctor's office practices.

Areas of activities for review include incorrect DRGs, inappropriate admissions, and quality of care. CFMC also provides physician review services for second level appeal review, as well as private review requests from out-of-state hospitals. We need doctors to help us, especially to avoid final judgment of clinical practice by non-physicians. When there is doubt about admission or DRG, we want the critical reasoning of practicing Colorado doctors to evaluate the clinical situation.

This is a paying job. It involves review of medical records (almost all inpatient). The records are delivered to you and specific questions are asked that call for clinical judgment. Selected physicians arc chosen because they are a professional peer of that doctor who admitted the patient and are also familiar with the DRG of the diagnosis and/or procedure. The current reimbursement rate is $100.00 per hour (remember, there is no overhead, so for some of us it's double that amount).

We have an orientation session and sample cases for practice, and physicians are also paid while training, Rarely will a review take as much as an hour. We anticipate no individual reviewer will have more than two or three charts a month. That is an option we can adjust to meet available time. We especially need sub-specialists in the following areas, but all interested doctors are welcome to apply:

Anesthesiology
Cardiology
Cardiovascular Surgery
Emergency Medicine
Gastroenterology
Neurology
Neurosurgery
Oncology
Oral Maxillofacial Surgery
Orthopedic Surgery
Pathology
Physical/Rehabilitation Medicine
Pulmonology
Radiology
Rheumatology
Thoracic Surgery
Urology

If you are interested, call (303) 695-3300, for the switchboard, then dial Extension 3351 and request that the preliminary application be mailed to you. We look forward to your application.

"Physician Employment Contracts" by C. Kay Freeman still available

C. Kay Freeman, author of the MGMA ***"Series of Strategic Agreements"*** publications titled: ***"Physician Employment Contracts"; "Physician Income Generation and Distribution"***; and ***"Administrator Employment Contracts"***, published and sold by Medical Group Management Association (MGMA), and through the AMA.

After three printings, the books, nationally acclaimed by physicians and attorneys, are no longer available through MGMA or AMA. However, a limited number are still available through Health Systems Strategies ("HSS"). Ms. Freeman said that "Physicians looking for this series of books, referred to me by MGMA, have recommended that I contact state medical associations to make the books available to members."

The books and their subjects are:

"Physician Employment Contracts" (Volume I in the MGMA Series of Strategic Agreements) - addresses: factors influencing physician employment contracts; evolving considerations in developing physician employment contracts; innovative trends in contracting; assessments of example contract terms found in physician employment contracts; complete examples of physician employment contracts; and complete examples of contract evaluation standards and related policies and procedures.

"Physician Income Generation and Distribution Plans" (Volume II in the MGMA Series of Strategic Agreements) - addresses: events influencing physician income and distribution plans; factors influencing revenue available for physician income distribution; prevalent inquiries regarding income distribution formulas; assessment of example terms found in physician income distribution plans; complete examples of physician income distribution plans; and systems, policies and procedures relating to income distribution plans.

"Administrator Employment Contracts" (Volume III in the MGMA Series of Strategic Agreements) - addresses: factors influencing administrator employment contracts; evolving considerations in developing administrator employment contracts; evolving administrator responsibility considerations; assessment of example contract terms found in administrator employment contracts; complete examples of administrator employment contracts; and complete examples of contract evaluation standards and related subjects.

Order Form for Publications

Physician Employment Contracts $25.00
Physician Income Generation and Distribution Plans $25.00
Administrator Employment Contracts $25.00
Plus Shipping of $10.00*
Please send check or money order to Health Systems Strategies, 1200 Abernathy Road, Suite 1700, Atlanta, Georgia 30328.

Please provide the following information, including a physical address not a P.O. Box, for delivery.

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* Shipping through Airborne Express.
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COPIC
COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



It's All Worth It, Believe Me

In the February 23 issue of the ***Journal of the American Medical Association***, Dr. Tom Delbanco reported the following:

"I received a kind letter from a patient's daughter after he had died, which included two sentences that struck me: 'We realized that sometimes the health insurance was as much a challenge as my father's illness, but you fought the battle with us. Please let all the people at the front desk know they are a wonderful bunch and we do appreciate them.' The first sentence is a sad commentary on our health-care system. The second sentence meant a lot to our staff."

What Dr. Delbanco didn't say was, "It's still all worth it," but he would have, if asked.

Four significant events have occurred in the past three weeks that further convince me of this, personally:

- Copic had its annual meeting -- At the meeting, a freshman medical student named Edna Ma presented her perspective on medicine and technology. She is a first-generation Chinese American and plans to spend her career in geriatrics. Besides representing the physician of the future, she also represents the Copic customer of the future. The Copic annual meeting also addressed how Copic may assist physicians with strategies (especially web-based strategies) that can decrease administrative costs and hassle for physicians, increasing their efficiency and time with patients and (hopefully) improving their financial success.
- The Physician Insurers Association of America (PIAA) held its annual meeting of CEOs/COOs -- The PIAA is the national trade association to which Copic belongs. Their meeting focused on the gradual increasing severity in medical liability settlements and the need to develop an e-commerce strategy. Copic's tort reform and risk management program have prevented the severity increase that other states are seeing. As noted above, Copic is already addressing the e-commerce issue. I should also note that several of our PIAA colleague companies have chosen to go the public, "Wall Street" route and have abandoned their original missions. Because many years ago Copic institutionalized its equity, you can be sure the Wall Street route will never be a considered option for Copic. The PIAA has also tried for seven years to get federal tort reform passed and plans to only "turn up the heat" on the same.
- The 4th Annual CMS/Copic Conference on the Medically Underserved was held -- Gary VanderArk, M.D., a past CMS President, recently chaired this conference. The room was filled to capacity with highly committed Coloradans who want to find a way for the underinsured in our state to get access to adequate insurance. A statewide solution is their goal for 2007. They have spent two years determining what to do, and now are working on how to do it. They, too, are committed, and they, too, think "it's worth it."
- One of my dear friends -- a mother of four and grandmother of four -- is in an Intensive Care Unit, on a respirator with adult respiratory distress syndrome precipitated by acute/severe pancreatitis. As my friend's family was struggling to understand how their very healthy mother and grandmother was, within a 48-hour period, facing 50% odds of surviving, I saw the dedicated health care professionals -- nurses, critical care physicians, and surgeons -- all battling to make her survival a reality. In their work, they weren't concerned about contracts, referrals, and authorizations, but rather how they could apply our science and art for her well-being and that of her family.

Dr. Delbanco knows it's worth it. Edna Ma knows it's worth her seven to ten years of study and dedication. The Board and management team at Copic know it's worth it, and the PIAA will continue to fight on a national level for you. Why? Because patients need you. And believe me, **it is worth it!**

NOTICE OF ELECTIONS

The following physicians have been nominated by the AMS Board of Directors for the 2000-01 term of office.

Jeremy A. Lazarus, MD, President
Clara L. Winter, MD, President-elect
Andy Fine, MD, Secretary
Robert L. Kruse, MD, Treasurer

Nominations from the floor must be received in the Arapahoe Medical Society office thirty (30) days prior to the Annual Meeting, which will be held on Thursday, May 18, 2000 besinning at 6:00 pm at the Wyndham DTC,

This notice is given in compliance with Article VIII.2 of the AMS Bylaws:

2. ELECTION AND TERM OF OFFICE. The Secretary and Treasurer of the Society shall be elected at the annual meeting of the Members of the Society. The President-Elect for the previous year shall succeed to the Presidency. The Secretary succeeds the President-Elect via the election process. The position of president and president-elect shall be affirmed by a vote of the membership. The Secretary is the Chair of the Professional Review Committee. The officers of the Society shall hold office for a term of one year and until their successors have been duly elected and qualified. All officers must be Active Members of the Society.

The Board of Directors shall prepare and submit to the membership by letter, in the newsletter, or by electronic transmission at least sixty days prior to the annual meeting, a ballot containing a single nomination for each office. Nominations from the floor must be received at least thirty (30) days prior to the annual meeting. If during the sixty day interval, the Secretary of the Society shall receive petitions in support of addifional nominees for any office containing at least five percent of ths Active Members, the Secretary shall cause to have those names added to the ballot. Election shall be by ballot and the majority of the votes cast shall be necessary to elect.

HELP FOR PHYSICIANS and their Practices Online!

AMA Solutions, Inc., a subsidiary of the American Medical Association, has moved its national consulting referral service, AMA ConsultingLink®, online. The AMA ConsultingLink network is a national referral network of pre-screened consultants offering consulting services in eight key strategic areas: strategic planning/development; marketing/public relations; information technology; quality assurance; operations and general practice management; human resources; and accounting.

Now it is even easier for a medical practice to reap the benefits of the AMAConsultingLink network at www.AMAConsultingLink.com. "We moved the AMA ConsultingLink network online to offer physician practices 24-hour access to the help they need. Those in need of a health care consultant are able to search by name, region, or area of expertise to find their ideal match," said Craig Samuels, product manager for the AMA ConsultingLink Network.

When physicians use www.AMAConsultingLink.com, they can view a list of qualified, pre-screened candidates with detailed background information.

Consultants in the AMA ConsultingLink network are very carefully selected. AMA Solutions has a rigorous application process that every consultant must go through before being accepted into the network. Only experienced consultants are accepted. Each consultant is required to send AMA Solutions:

- their resume
- three physician references
- history of working with physician practices (3 years minimum required)
- percentage of time spent working with health care clients
- description of 2 projects in each area of expertise
- accountant's certification letter

Physicians and physician practices can access the AMA ConsultingLink network by calling 800-366-6968 or by accessing www.AMAConsultingLink.com 24 hours a day.

AMA Solutions, Inc. is a subsidiary of the American Medical Association. Formed solely for the purpose of providing solutions to physicians and medical practices, AMA Solutions continues to grow through its market-driven philosophy of meeting the market's needs by developing innovative physician-tailored personal and office-based product solutions. For information on other programs for physicians and their practices, visit www.AMASolutions.com or call 800-366-6968.

CPEP to be Model for National System of Physician Evaluation Centers

Colorado Personalized Education for Physicians (CPEP) announced early in March that it will become the model for, and the first center in, a national system of physician evaluation centers pursuant to an agreement reached with the National Board of Medical Examiners (NBME), of Philadelphia, Pennsylvania.

The NBME and the Federation of State Medical Boards (FSMB), the national liaison organization for state medical boards, are collaborating to develop the Institute for Physician Evaluation, a national system of physician evaluation centers designed to assist state medical boards in assessing the clinical competency of physicians demonstrating quality of care problems.

The NBME acquires CPEP's physician assessment process and CPEP agrees to work with the NBME to conduct physician evaluations as the Institute for Physician Evaluation in Colorado (IPE-Colorado). The IPE-Colorado, which is expected to open April 1, 2000, will be a valuable resource for the physicians, hospitals, licensing boards and others that have historically relied on CPEP's in-depth analysis of physicians' practice skills.

CPEP will continue to offer educational interventions for physicians and will also partially off-set participation costs for Colorado physicians.

NBME president L. Thompson Bowles, MD, stated "The NBME is pleased to have CPEP serve as the first in what will ultimately be a regional system of assessment centers designed to assist state licensing authorities and healthcare providers in improving the quality of care provided by physicians." James R. Winn, MD, chief executive of the FSMB, concurs, noting "The Institute for Physician Evaluation will significantly enhance the ability of state medical boards to protect the public by providing objective information about physicians whose deteriorating practice skills pose public safety concerns. By referring such physicians to the IPE, state medical boards are better prepared to mandate remediation programs that focus on the physicianís deficits, thus attempting to salvage a community resource without compromising public safety."

CPEP, founded 10 years ago by a consortium of Colorado medical organizations, has provided assessment services to hundreds of physicians from Colorado and other states. The vision and support of the Colorado medical community has led to CPEP's emergence as a nationally recognized physicians assessment program. According to Arja P. Adair, Jr., CPEP Board President, "The CPEP Board is enthusiastic about this opportunity to work with the capable leadership of the FSMB and the NBME." Andrew M. Wiesenthal, M.D., CPEP Board President-Elect, adds "CPEP's participation in this national system of physician evaluation carries its mission to a nationwide audience and provides an unparalleled opportunity to preserve and enhance the vision of CPEPís founders."

The FSMB and the NBME, partners in the development and administration of the United States Medical Licensing Examination, have a long history in medical evaluation and licensure.

HMO Group Launches Ad Campaign: It's The Doctor's Mistakes That Are The Real Problems

According to a recent Associated Press story from Washington, D. C., the American Association of Health Plans is launching an ad campaign in an attempt to convince the American public that it is the doctors' mistakes and not the managed care plans that are the real problem with health care in this country.

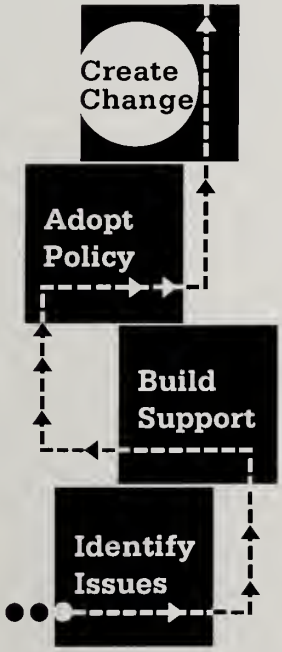
The Association is spending $200,000 on TV ads over a two week period beginning in early April. The ads say that "medical mistakes can kill." The ad suggests that the solution is to "get patients the care they need instead of getting lawyers the clients they want."

The ad, according to the Associated Press story, aim to drum up support for a proposal that would require doctors and hospitals to report all serious medical mistakes to a federal agency. The Institute of Medicine released a study in November showing that as many as 96,000 people are killed annually because of medical mix-ups.

The American Medical Association Organized Medical Staff Section (AMA OMSS) invites your medical staff to be represented at its

2000 Annual Assembly Meeting

June 8-12, in Chicago



The OMSS is a powerful voice, advocate, and resource for empowering hospital and other health care entity medical staffs. The OMSS meets twice year to:

- **Identify issues** of critical importance to medical staffs, such as on-call emergency coverage and EMTALA guidelines, scope of practice, "exclusive credentialing," HCFA regulations, and medical errors;
- **Build support** for these issues through educational programs, special issue forums, state and regional caucuses, reference committee hearings, the OMSS Assembly, and the AMA House of Delegates; and
- Persuade the AMA to **adopt policy** that will further the needs and concerns of medical staffs; so as to
- **Create change** at various levels within the public and private sector in an effort to improve the quality and delivery of medical care and the professional and personal success of physicians

Elect a member of your medical staff to serve as an OMSS representative* and attend the **2000 Annual AMA OMSS Assembly Meeting**. Topics for educational programs include:

- communication basics, team building and problem-solving
- on-call emergency coverage and EMTALA compliance
- scope of practice
- medical staff bylaws and the changing environment
- building "win-win" relationships between medical staffs and hospital/IDS administration
- status of legislative initiatives
- medical errors
- the impact of MCO insolvency on physician practice

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at **omss@ama-assn.org**

*Must be an AMA member

American Medical Association

Physicians dedicated to the health of America

Colorado Commission on Family Medicine Regional Job Fair

The Commission on Family Medicine is changing the way we provide communities the opportunity to meet with new family medicine residents. This year the Commission will host four Regional Job Fairs in different parts of the state. While the exact locations haven't been set, the dates and areas have: Friday, July 28 in Denver; Friday, August 25 in Grand Junction; Friday, September 22 in Windsor and Friday, September 29 in Pueblo.

The main purpose of the Regional Job Fairs is to bring together second and third year Family Medicine residents from Colorado's ten residency programs with representatives from rural communities and practices who have either an immediate need for family physicians or anticipate a future family physician need. The casual environment at the Regional Job Fairs will create a comfortable arena in which both community representatives and residents can share thoughts and ideas in an attempt to find a good match.

The second key element of the Regional Job Fairs Fair is education. Management skills as broad as understanding managed care systems and contract issues to more finite tasks such as preparing a curriculum vitae and interviewing will be addressed.

The Regional Job Fairs are developed by Tony Prado-Gutierrez, Executive Director and Jill Olin Parks, Program Associate for the Commission on Family Medicine. For more information on the Regional Job Fairs, please contact Tony Prado-Gutierrez, 303-315-9734 or Jill Olin Parks, 303-315-9727, fax, 303-315-9752 or email: jill.olinparks@uchsc.edu

OIG Issues Special Fraud Alert on Rental of Space in Physician Offices by Persons or Entities to Which Physicians Refer

The Inspector General for the Department of Health and Human Services has issued a fraud alert for physicians concerning rental of space in their offices by persons or entities that provide health care items or services to patients that are referred, either directly or indirectly, by the physician-landlord. When the Office of the Inspector General (OIG) identifies practices in the health care industry that are particularly vulnerable to abuse they will issue a Special Fraud Alert. In this case the OIG is focusing on rental arrangements that may be disguised kickbacks to the physician-landlords to induce referrals.

The rental arrangements they mention specifically are:

- Comprehensive outpatient rehabilitation facilities (CORFs) that provide physical and occupational therapy and speech-language pathology services in physicians' and other practitioners' offices;
- Mobile diagnostic equipment suppliers that perform diagnostic related tests in physicians' offices; and
- Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that set up "consignment closets" for their supplies in physicians' offices.

The OIG is looking at the rental arrangements to determine the appropriateness of (1) the rental agreement, (2) the rental amount, and (3) time and space considerations. These are indicators the OIG uses to investigate potentially unlawful activity.

If you would like to obtain a copy of this alert you can contact Marilyn Rissmiller at CMS on (720) 859-1001 or 1-800-654-5653. The alert is also available on the internet at http://www.dhhs.gov/progorg/oig/frdalrt/index.htm.

Find out what's happening in Colorado health care.

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Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

On Monday, March 13, 2000, Rocky Mountain HMO (RMHMO) created a seat for the Colorado Physician Network (CPN) on its Board of Directors. We have been attending regularly for quite some time as an invited guest, and we were delighted both by the decision and its significance.

In this era of rising costs and financial losses, CPN leadership is working diligently with RMHMO to provide appropriate reimbursement for our physician panel, while attempting to control losses on the Front Range. Recent intensified efforts have significantly improved our balance sheet, but much additional strategic modification is required and planned.

We salute RMHMO, both for this symbol of commitment, as well as the complex on-going effort it represents. Likewise, we pledge CPN's resolve to vigorously pursue creative initiatives and effective solutions. Thank you, RMHMO!

Colorado Personalized Education for Physicians

Responding to Peer Review Concerns through In-depth Assessment and Education

CPEP

For more information, write or call:

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Aurora, CO 80014
(303) 750-7150
FAX: (303) 750-7171
CPEP@cpepdoc.org

Peer Review: No matter the outcome, these words can mean financial hardship, anxiety, and the loss of countless hours for physicians and medical organizations alike.

Colorado Personalized Education for Physicians (CPEP) can help. Nationally recognized, CPEP is dedicated to helping physicians assure excellence in patient care. CPEP has assisted hundreds of physicians around the country through its program of individualized assessment and education.

Physicians, hospitals, managed care organizations and state licensing boards rely on CPEP's in-depth analysis of physicians' skills. Moreover, CPEP's customized learning plans address peer review concerns when the need for educational intervention is evident.

With increasing pressure on physicians at both the local and state level, the need for this positive alternative has never been greater.

The Physician's Role in Organ and Tissue Donation*

by Patrick Murphy
the Donor Alliance

Physicians are trained from the beginning of medical school to keep their patients alive and well. The full gamut of medical resources - including the latest drugs, procedures and technologies - are at their disposal. Yet when patients succumb to illness or injury, expected or not, doctors are involved not only to provide dignity for the patient, but also to comfort family members. Relatives look to the attending physician for answers and guidance.

Donation can be an enormous source of consolation and even hope to the donor family. It can provide a sense that something positive, something life-giving can come from the death of a loved one. As the family's physician you can reassure them that everything possible has been done, that many people in medical need will benefit from the donation of their loved one's organs and/or tissues, and that the body will be treated with respect. Most importantly, you can support them in whatever decision they make.

Also, if you serve as patient's primary physician you have a unique opportunity to address donation with your patients. Many physicians routinely educate their patients about healthy lifestyles, medication compliance, and even advanced directives. Asking patients about their preferences for organ and tissue donation is a natural extension of this relationship.

Tissue Donation: The Overlooked Facts

1) Tissue can be donated following cardiac death, not just brain death, as is required for organ donation.
2) All organ donors can be evaluated for tissue donation. Tissue donation occurs more frequently than organ donation.
3) Almost anyone can be a tissue donor - from newborn to 80 years of age.
4) The demand by far exceeds the supply for bone, skin and cardiovascular tissues, in large part because not enough emphasis is put on tissue donation.

Find out what's happening in Colorado health care.

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◆ ***PROFESSIONAL OPPORTUNITIES***

LAFAYETTE, CO - Seeking physician for urgent/emergent care center affiliated with Boulder Community Hospital. Hrs 7 am - 11 pm. Flexible shifts. Excellent support staff. ACLS, ATLS, emergency experience required. Fax CV with cover letter to medical director (303) 666-9247. Phone (303) 666-4357. 12/0999

PUEBLO, CO - BE/BC physician needed for hospital based occupational medicine clinic. Excellent compensation and benefit package. Contact Chris Hildebrant (719) 475-9496 send resume to 1633 Medical Centerpoint, Suite 103, Colorado Springs, 80907 12/1199

◆ ***PROFESSIONAL OPPORTUNITIES***

PART-TIME ORTHOPAEDIST WANTED ASPEN & GLENWOOD We are recruiting a part-time orthopaedist to assist us in our offices and as a surgical assist (spine surgery). Live and work in the beautiful Roaring Fork Valley. Fax or mail your CV to George Trantow, Executive Director, Orthopaedic Associates of Aspen & Glenwood, 100 East Main Street, Aspen, CO 81611, Fax (970) 927-8633. 06/0100

BOULDER - EXCELLENT OPPORTUNITY for Board Certified MD in Urgent/Family/ Occupational care. Reply to Medical Director, Meadows Medical Center, PC 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 04/0200

◆ ***PROFESSIONAL OPPORTUNITIES***

PARIS, TEXAS - Seeking BC/BE gastroenterologist, neurologist, general surgeon, and internist. 198-bed regional hub serving two-state, 10 county area seeks physicians who want to practice quality medicine. Great opportunity! Strong, diverse economy with 4 Fortune 500 industries. Family oriented community with ample youth activities 25,000 city population/48,000 county. Golf, fish, hunt, hike all nearby. Send CV to Mike McBride, FACHE, Executive Director, 865 DeShong Drive, Paris, TX 75462-2097, or fax (903) 782-2840. For a packet of information on McCuistion and community fax or e-mail to mcbridm@phscare.org. 03/0100

ROCKY FORD – LOWER ARKANSAS VALLEY - Seeking FP to join small primary care group practice with three offices plus satellite. Breadth of FP, with OB optional. Competitive salary guarantee and fringe package. Collegial atmosphere, great recreational opportunities, good schools and economical housing. Potential for loan repayment. Prefer female. Contact M.J. Berg, MD or Randy Evetts, MPA, (719) 254-7421, fax (719) 254-6966, E-mail MJberg@iguana.ria.net. 06/0300

Cheyenne, WY - Large MSG needs a B/E, B/C Internist **ASAP**. Highly competitive salary, benefits and insurance. No State Income Taxes. No heavy traffic. Call Barry at Sullins & Associates; (303) 986-1909 or fax CV to (303) 986-1509. 02/0300

MEDICAL DIRECTOR-Part-time for Denver based HMO. Licensed physician with good knowledge of evidence-based medical practice for evaluation of appropriate care. Contact Charles Barta, MD, Community Health Plan of the Rockies, Inc., 400 South Colorado Blvd., Suite 300, Denver, CO (303) 355-3220 ext. 3240. 04/0300

Colorado Foundation for Medical Care

MEDICAL DIRECTOR

CFMC, the Peer Review Organization for Colorado and the premier medical QI organization in the State, is soliciting candidates for the position of Medical Director. The position reports to the Board of Directors, and is responsible for the direction of medical/clinical activities and policies of the organization relative to strategic objectives.

We are seeking a senior level physician (MD/DO) with a minimum of ten years clinical experience, board certified and currently licensed in Colorado. The ideal candidate will possess a thorough understanding of continuous quality improvement processes, be well versed in Medicare and Medicaid programs and have a comprehensive knowledge of the Colorado medical community. This position requires a strong, collaborative leadership style and the ability to interact positively with a diversified customer base, including medical organizations, governmental agencies, legislative bodies, academic centers and service providers. Excellent interpersonal communication, team building, and presentation skills are required.

Resumé/C.V. should be submitted by April 15th to:

Director, Human. Resources
Colorado Foundation. for Medical Care
2851 S. Parker Road, Suite 200
Aurora, CO 80014

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

No 'April Fool' joke, this announcement! She means it!

Peggy Fogel, Pueblo County Medical Society (PCMS) Executive Secretary is retiring. . . no "ifs", "ands", or "buts" about it. And her retirement begins April 1, 2000. She's caused me to think a lot about the issue, and I've decided that Peggy is nobody's (especially April's) fool. Why March 31st as the last day? When she made up her mind that there were other things in life besides work, she just picked a date.

Peggy started for the PCMS in 1979. Prior to that, Peggy, former wife of a physician, gave in to a friend and went to work part-time for the Southeastern Colorado Dental Society. Not long after that, another friend, Dr. Wes Boucher of Pueblo and President of PCMS at the time, said, in effect, "Why don't you do that for the Medical Society?" Peggy replied that she would, until she could find something that paid better and would be full-time. 20 years later she's finally going full-time, in retirement, and the rewards will be great.

She's been a Pueblo resident for 40 plus years, has three children, all grown and successful in their own fields. Her youngest daughter is a Washington, D.C. psychologist and her husband, also a psychologist with the American University. A second daughter who attended Radcliff, married a boy at Harvard who became a physician, and they are still living in a Boston suburb. He attended medical school at the University of New Zealand.

Peggy's son is a computer consultant in Pueblo, taking care of the computer needs in professional offices, such as attorneys and physicians.

Yes, there have been many changes in the field of medicine since Peggy started, one of the biggest in her mind is the fact that physicians used to pay so little attention to the state legislature. Now, she says, the legislature controls the physician's practice. Some of the doctors, she adds, still don't realize what has happened to their profession. Peggy recalls Larry Wood, former general counsel to the Colorado Medical Society, in 1980 telling the doctors that this is precisely what would happen down the road. Here we are, she says, 20 years down the road, and Larry Wood's prediction has come true.

Peggy notes also that managed care is what really changed medicine and doctors, forever.

Peggy recalls medical practice was pretty much an all-male profession when she started with PCMS, and that has changed dramatically. Women physicians are becoming more and more the order of the day, and people feel better about that. This change has had a tremendous influence on health care. Peggy recalls that the phone calls requesting the name of a female physician increased considerably in just the past three years of her work.

I asked Peggy where she was born and she said "I was born, lived and studied at Stanford. My father was a professor of Aeronautical Engineering. I majored in History and minored in Mathematics. I married there and then worked to put my husband through medical school. We moved 25 times during his school, internship, residency and practice. It was quite a shock when we finally came to Colorado, but I'm right at home in Pueblo now."

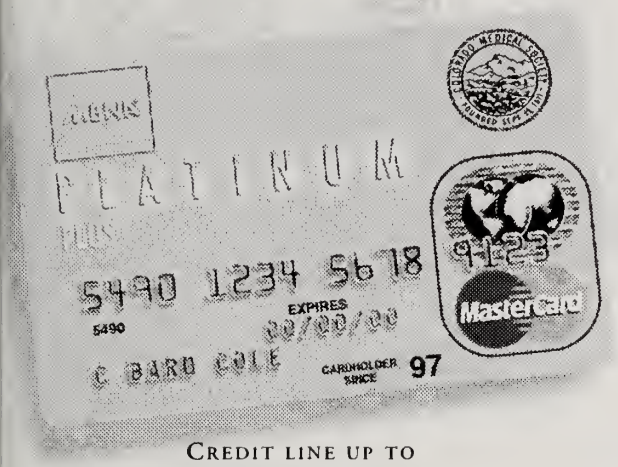
She says she may take some classes at Community College or at the Univ. of Southern Colorado, "just for fun." However, right after March 31st she is taking it easy and is enjoying saying "No" to many requests on her time.

Well, Peggy, over these years we have had a lot of fun; you've many times been a big help to me in ways you didn't even realize because you know how folks in Pueblo think, and you knew how the Pueblo physicians felt about a lot of things. You've been a value to all of Colorado organized medicine, and a pleasure to work with for those of us in the field. Best wishes, Peggy.

You know, the more I think about it, **I** am probably the classic April Fool: if I were retiring on March 31st, I wouldn't have to finish this gigantic move of CMS to our new quarters.

March 31st would have been a **perfect** day to retire. But, then again, what day wouldn't?

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David E. Bates, M.D.

July 17, 1922 - March 30, 2000

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COLORADO MEDICINE

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Cover Story

This is a portrait of Dr. Bates which hangs in the North Colorado Medical Center, home of the Family Practice Residency Program.
Dr. Bates was the program's first Director.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

Again this year, the American Medical Association's National Leadership Conference was extraordinarily interesting and informative. Held in Miami March 25-28, it was attended by myself, your president-elect, several members of your AMA delegation and officers from several of our CMS component societies. While information was presented addressing a broad spectrum of issues, what this meeting did most for me was to bring into focus the myriad of important functions the AMA performs for all of us, the ordinary physicians in the diverse community of medicine.

I have often heard the lament; "Why should I belong to the AMA, what has it done for me?" Though the AMA has done much for all physicians, perhaps we need to get past this "What's in it for me" philosophy and as physicians truly realize our societal potential by asking the bigger question, "What's in it for my patients and society?"

I will admit, during my years of practice, unless I faithfully read the AM News and dug in the literature it was hard to realize the AMA was active at all. The organization tries to communicate information about it's activities but there is often not time for the practicing or academic physician to read and digest this lower priority information. I can only hope to delude myself you will take the time to read this with the understanding of my history of years in the trenches of medicine but now having the time to immerse more deeply in the intricacies of the AMA.

Some of the things I did not realize in my years of practice and relative isolation from the AMA follow. I will tell you first, I am amazed at the high caliber of medical minds that are gathered together in the leadership of the AMA. Officers through delegates, practicing and academic physicians of all specialties, these are the cream of the crop of medical minds in our country and it has been an honor to work and learn among them. So, what are they doing in the national and state forum you should be aware of?

On the political front, the AMA subjects national and state policy to a single criteria; Is this good medicine for physicians and their patients? Some of the action the AMA is taking to answer this question are:

- Endorsing and shepherding the Patient Bill of Rights through Congress. This key bill addressing many onerous provisions of managed care, especially holding managed care entities legally accountable for their actions was authored by physician and dental congressmen. Without AMA support and action this bill would have long been dead, but with it's support it is through one house and in joint committee and has very good possibility for passage in meaningful form with bipartisan support.
- The Campbell Bill offering antitrust relief to all physicians, not just the employed or those sharing risk. This bill would allow physicians to legally join together collectively to equitably negotiate with managed care and even governmental entities. With AMA support this bill is moving forward despite massive majority opposition. Without that support, this bill would be dead.
- Restoration of a 5.4% Medicare reimbursement discount imposed by HCFA this year. As the result of inaccurate calculations by HCFA this multibillion dollar reduction in reimbursement was to have been withheld from legislated physician reimbursement this and subsequent years. The AMA with the support of other physician organizations pointed out this error and obtained reinstatement of and accurate calculation of these Medicare funds for physician reimbursement.
- Institution of National House Call 2000. AMA leadership hit the road during the presidential primary season to personally and directly make the candidates and the voters aware of the AMA's requirements for physician's support in their campaigns. They were clearly heard as candidates position's changed regarding national health care issues and voters responded with positive feedback and votes reflecting AMA leadership's efforts. Those AMA positions (demands) include:

  1. Universal healthcare coverage for all Americans providing access to all for basic appropriate health care.

  2. Patient protection and anti-trust relief for physicians as outlined above to remove the onerous systems prevalent in managed care.

  3. Anti-tobacco use policy, especially use of all tobacco settlement money in the health care arena and for anti-tobacco education.

  4. Most importantly, as an essen-

(Continued)

tial element of House Call 2000, the AMA is calling for a fundamental rethinking of our nation's system of health care financing that would restore the patient-physician relationship as it concerns provision of care and physician payment for that care. This relationship must be one of trust, too often these relationships are disrupted not because of patient dissatisfaction but because of decisions imposed by the patient's employer (by choice of health plan) or by the health plans themselves. The incentives for meaningful interaction between patient and physician are in all the wrong places. In June 1998, the AMA House of Delegates adopted a set of recommendations that would shift decision making authority from employers and health plans to individual patients.

Individually owned and purchased health insurance made possible by defined contributions from employers and basic defined benefits subsidized for the underprivileged would go a long way toward restoring the patient-physician relationship with proper incentives rewarding appropriate quality care rather than limitation of care. How the AMA will fulfill this, its current primary long term goal, is defined in an article in the October 21, 1999 *New England Journal of Medicine* Vol. 341:1305-1308. This is well worth your reading time. I believe it is our future.

The AMA is accomplishing much more in many other arenas and there is only space here to name some of these, such as:

- private sector advocacy for patient's rights;
- legal action on behalf of physicians in their managed care tribulations;
- programs to restore physician collegiality;
- education regarding palliative care (Education for Physicians for End of Life Care [EPEC]);
- integration of use of the internet into medical practice, and;
- support of the AMA Alliance in their ***Stop America's Violence Everywhere*** (SAVE) program.

All physicians in this country benefit from the activities of the AMA but the tragedy is a minority of physicians support it's activities. It is time for all physicians to ask the right question: "What's in it for me, my patients, society and medicine's future," and recognize the AMA as our most important national voice. If you are not a member of the CMS and the AMA, accept your responsibility and contact our membership department to join now.



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CMS Med Fax®

. . . a compilation of medically-related news briefs of immediate interest to the physician community occurring after COLORADO MEDICINE has gone to press. **AT PRESS TIME . . .**

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Peer Review Under Attack?

by Richard L. Murray, Jr. & Patrick T. O'Rourke

The State of Colorado endorses physician peer review. Several years ago, when it passed the Colorado Professional Review Act, the General Assembly recognized that the Colorado Board of Medical Examiners needs assistance from peer review committees to properly carry out its mandate to protect the public health and welfare. *C.R.S. §12-36.5-103(1).* Accordingly, the General Assembly declared that peer review is "an extension of the authority" of the Colorado Board of Medical Examiners. *C.R.S. §12-36.5-103(3)(a).* Nonetheless, there is a recognized legal tension between needing to police poor quality medical care, limiting potential anticompetitive influences in peer review, and protecting the civil rights of a physician whose care is being reviewed.

To promote physician participation in peer review, the State of Colorado immunizes physicians who serve on peer review committees and who testify before peer review committees from liability, so long as those physicians act in good faith and with a "reasonable belief that the action taken by him was warranted by the facts." *C.R.S. §12-36.5-105(1).* Unfortunately, to determine whether a physician has acted in good faith while serving as member of a peer review committee or as a witness before such a committee can require extended litigation about the physician's motives for participating.

To create oversight of the peer review process, the General Assembly created an administrative entity known as the Committee on Anticompetitive Conduct (the "CAC"). The CAC operates as an independent committee of the Colorado Board of Medical Examiners and is charged with reviewing professional review actions occurring in the State of Colorado. *C.R.S. §12-36.5-106(1).* In fact, the CAC's sole purpose is to oversee professional review proceedings and determine whether any particular professional review action "resulted from anticompetitive conduct." *C.R.S. §12-36.5-106(9)(f).*

Any physician who claims that his hospital privileges have been terminated or restricted as a result of unreasonable anticompetitive conduct may petition the CAC and request a hearing on the propriety of the professional review action. *C.R.S. §12-36.5-106(7); C.R.S. §12-36.5-106(9)(a).* At the hearing, which is conducted under Colorado's Administrative Procedure Act, the aggrieved physician can subpoena witnesses, introduce exhibits, examine and cross examine any witnesses, and present argument to the committee. After the hearing, the CAC may disapprove, set aside, or modify any professional review action that resulted from anticompetitive conduct. *C.R.S. §12-36.5-106(9)(k).*

Until recently, the Colorado Court of Appeals required a physician who was aggrieved by a peer review action to submit his or her claims to the CAC *before* bringing a civil suit in the Colorado courts. In *Ryals v. St. Mary Corwin Regional Medical Center,* a neurologist claimed that he

(continued on next page)

CMS Med Fax

was unfairly excluded from reading MRI's at St. Mary Corwin Hospital because of an exclusive contract between the hospital and a radiological group. His civil lawsuit asserted several common law causes of action against the hospital and a number of physicians, including breach of contract, promissory estoppel, tortious interference with contractual relations, and outrageous conduct. Dr. Ryals argued that he was not required to submit his claims to the CAC because it could not provide him with the monetary damages that he sought in his civil case. He also argued that the CAC's jurisdiction was not intended to preclude physicians who were "otherwise aggrieved by the final action of a governing board from seeking other remedies available by law . . ."

Less than two years ago, the Court of Appeals unanimously rejected Dr. Ryals' arguments and found that all of his allegations against the hospital were based upon "alleged acts that constitute unreasonable anticompetitive conduct." Accordingly, the Court of Appeals determined that Dr. Ryals could not bring a civil lawsuit against the hospital or any of the physicians who participated in the peer review process without first submitting his claims to the CAC. The *Ryals* decision seemed to support a conclusion that an aggrieved physician could not use creative pleading to avoid the CAC's jurisdiction. Instead of looking at the relief sought in the lawsuit, *Ryals* directed trial courts to look at whether the underlying facts are premised upon allegations of "anticompetitive conduct."

All of this changed earlier this month when the Colorado Court of Appeals released its opinion in *Pfenninger v. Exempla*. In the *Pfenninger* case, Dr. Pfenninger alleged that his medical staff membership at Exempla Lutheran Medical Center was terminated through improperly motivated and conducted peer review proceedings. Dr. Pfenninger alleged that his competitors made false allegations resulting in the summary suspension and revocation of his hospital privileges. Like Dr. Ryals, Dr. Pfenninger argued that he was not required to present his claims to the CAC because the CAC could not vindicate his reputation or award him any monetary damages. The trial court dismissed Dr. Pfenninger defamation claims against the hospital and his competitors because he had not pursued his claims through the CAC

The Court of Appeals agreed with Dr. Pfenninger. Because the CAC could not provide the remedies that Dr. Pfenninger sought against the hospital and the physicians who allegedly participated in the peer review process, the Court of Appeals found that it would be futile for Dr. Pfenninger to submit his claims to the CAC before filing them in court.

The *Pfenninger* case reaches a result that is inconsistent with the *Ryals* case decided only two years earlier. *Ryals* recognized that the CAC could not provide the relief that Dr. Ryals sought, but concluded that the CAC's jurisdiction would reach all claims based upon a theory of unreasonable anticompetitive conduct. *Pfenninger* adopts another analytical framework and directs trial courts to look primarily at the nature of the relief requested in the lawsuit, even if the lawsuit itself alleged that the tortious acts took place as part of an alleged conspiracy to eliminate competition. The *Ryals* case is currently pending before the Colorado Supreme Court, so we are hopeful that a future decision will instruct the Colorado trial courts on the correct method of evaluating whether a claim is within the CAC's jurisdiction. We expect a final opinion in the *Ryals* case later this year.

Where does this leave physicians and peer review? The *Pfenninger* case seemingly invites physicians who are aggrieved by a peer review action to bypass the CAC and bring lawsuits against the members of peer review committees and the witnesses who testify against them. *Pfenninger* allows such lawsuits, so long as the aggrieved physician seeks relief that is different than what the CAC could provide, such as monetary damages. Ultimately, if the jury concludes that the participants in the peer review process acted in good faith, they will prevail. Unfortunately, "good faith" and motivation are difficult to resolve without a trial and without fairly extensive pre-trial discovery. Because it allows lawsuits to proceed without exhaustion of the CAC's administrative remedies, the *Pfenninger* case exposes peer review participants to an increased likelihood of civil litigation stemming from peer review activities. Regrettably, *Pfenninger* means that hospitals and physicians should involve their counsel very early in the peer review process and throughout any hearings to minimize the peer review participants from retaliatory civil lawsuits. On the positive side, counsel's involvement may help ensure that the peer review action will be built upon solid legal and factual ground, thus ensuring that the affected physician's due process rights are adequately protected.

CMS Med Fax

Scholarships awarded by CMS Education Foundation to four first-year medical school students



John F. Farrington, MD, President of the Colorado Medical Society Education Foundation (CMSEF) is shown with the four first-year medical students at the University of Colorado who were awarded scholarships of $5,000.00 each. The students are (l to r) Jeni Marks, Caitlin Gustafson, Chuck Bennett and Soheap Na.

The Colorado Medical Society Education Foundation in April announced the award of $5,000.00 scholarships to each of four first-year students. At the presentation, Dr. John F. Farrington, CMSEF President, asked each of the recipients their reasons and motivation for attending medical school. Three of the students are from Colorado and the Rocky Mountain Region, and the fourth is from Thailand.

Each of the students replied they have high hopes of making a difference in the delivery of health care, particularly to people who are presently underserved.

Dr. Farrington made it clear to the students that their awards were made possible by physician members of CMS who are currently practicing and who want to see the development of a physician body to carry on with practices as part of the best medical care system in the world.

Dr. Farrington also reminded Colorado Medicine of the new gift program in which people can make a gift to the Foundation to help in the scholarship program in honor of another worthy person. These gifts are not limited to holiday giving, but can be made at any time of the year. For information, call (720) 859-1001, Ext. 6306.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Health Promotion Excellence in the New Century: Ascending New Heights
May 16 - 19, 2000
Adam's Mark Hotel
Denver, Colorado
Contact: Kate Demas (202) 408-9804 or *Kdemas@sophe.org*

4th Annual Symposium, Contemporary Approaches to the Management of the Risk Factors for Cardiovascular Disease
May 19, 2000
Denver, Colorado
Contact (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

Level II Physician's Re-accreditation Seminar
June 16-17, 2000
Antlers Adams Mark Hotel
Colorado Springs, Colorado
Contact: (303) 575-8763

5th International Conference on Pediatric Trauma
June 17-20, 2000
Vail-Beaver Creek, Colorado
Contact: (719) 365-5888 or *www.pedtraumaconf.org*

9th Annual Rural Health Conference
June 21-23, 2000
Gunnison, Colorado
Contact: (303) 832-7493 or (800) 851-6782

Teens and Trauma
June 29-30 and July 1, 2000
Grouse Mountain Lodge
Whitefish, Montana
Contact: (406) 752-1775

Internal Medicine Program
July 9-14, 2000
YMCA of the Rockies/Estes Park Center
Estes Park, Colorado
Contact: (303) 372-9065

Colorado Academy of Family Physicians Annual Scientific Meeting
July 20-22, 2000
Sheraton Steamboat Resort
Steamboat Springs, Colorado
Contact: (303) 696-6655 or *E-Mail: cafp@iex.net*

"Women Physicians: Finding a Balance"
July 20-23, 2000
Iron Horse Resort at Winter Park
Winter Park, Colorado
Contact: (303) 470-3441

Renal Disease and Electrolyte Disorders
July 24-28, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

26th Annual Psychiatry Conference
August 2-4, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

Neurology Update
August 4-6, 2000
Aspen, Colorado
Contact: (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

How To Practice Evidence-Based Health Care
August 6-10, 2000
Sonnenalp Resort
Vail, Colorado
Contact: sharlyn.walling@uchsc.edu or call (303) 315-7606

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Update on Infectious Diseases in Primary Care
September 16, 2000
The Antler Adam's Mark
Colorado Springs, Colorado
Contact: (303) 372-9065

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.



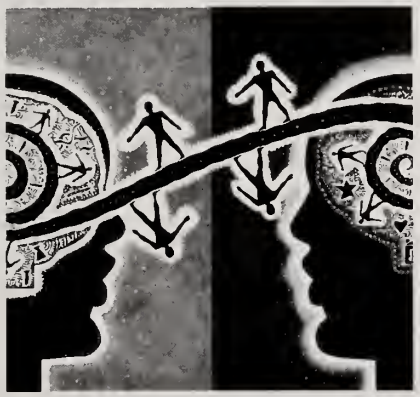
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Peer Review: No matter the outcome, these words can mean financial hardship, anxiety, and the loss of countless hours for physicians and medical organizations alike.

Colorado Personalized Education for Physicians (CPEP) can help. Nationally recognized, CPEP is dedicated to helping physicians assure excellence in patient care. CPEP has assisted hundreds of physicians around the country through its program of individualized assessment and education.

Physicians, hospitals, managed care organizations and state licensing boards rely on CPEP's in-depth analysis of physicians' skills. Moreover, CPEP's customized learning plans address peer review concerns when the need for educational intervention is evident.

With increasing pressure on physicians at both the local and state level, the need for this positive alternative has never been greater.

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We'll say it again. . . in a complete primer on doctor retirement, in the June issue of Colorado Medicine: Just how do I go about closing my practice or taking myself out of active practice? How do I sell my practice? What are the myriad other questions I should be asking myself about how I take care of my own welfare aas well as that of my patients?

Watch for it!

June, 2000: "Doctor Retirement; how do I do it?"

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Fascinating how some things, no matter how critical they may seem, it is difficult to even give them away. That's the way it's always been with health education. . . until the past few years. Health education became a crusade with CMS member Leo Nolan, MD, who practiced OB/GYN in Lakewood for many years.

Dr. Nolan decided that people were not being very good patients and the reason was the way they treated their mind and bodies. Therefore, how could you begin to teach these people that life can be so much more enjoyable and productive if you take care of yourself? That was a big question. But then, he heard of a health education center in the eastern US and thought, "This could be the tool." He got a few good people together and they, in turn, enlisted the aid of many other people who helped them organize and found what was first the Colorado Health Information and Eduction Center. In 1977, it officially became the Hall of Life (HOL).

It was a big, empty room in the Blue Cross Blue Shield of Colorado building when they first started, but the Hall of Life grew slowly as it took on a life of its own.

The HOL struggled until someone thought it a good idea if the organization could merge with the Denver Museum of Natural History. The Museum's Board Chairman, Charles Gates, thought that health education was a very basic part of natural history and could rightfully become a component under the museum's umbrella, typical of IMAX Theatre and the Gates Planetarium.

In the mid-1980s the Hall of Life took up residence in the new east wing of the museum, and has continued to grow ever since. The Hall of Life now receives thousands of student visitors each year, and has logged 196,443 program participants thus far, with over 5 million program and exhibit participants since 1975.

The Hall of Life's health education staff of 25 is of the finest in the state, many with years of successful teaching behind them.

When you stop to think about these numbers, this institution is awe-inspiring. Coupled with the hope that each person took away some tiny grain of information which might make them a healthier individual, that makes this a vital undertaking.

The Hall of Life health education programs have been shaped over the years by its Advisory Council, currently chaired by Kathy Gardner, BSN, PhD., of Copic Insurance Company. Kathy's principal pursuit has been and is health education.

Colorado and Denver Medical Society Alliance members have been very active in the Hall of Life. Through their fund-raisers, many children have been provided scholarships to attend HOL classes. Their members have been active and working participants on the Board of Directors. Others have volunteers in a variety of jobs in the HOL.

The Hall Of Life is now 25 years old and has won a spot as the premier health education center of the Rocky Mountain Region.

Many CMS member physicians have participated as volunteers in HOL activities, but many more are always needed.



Kathy Gardner, BSN., PhD
Copic Insurance Company
Chair, Advisory Council
The Hall of Life

Hard as the public schools and teachers try, there's much to be desired in health education for children, K through 12. That's why the Hall of Life was designated by the Colorado Medical Society as a service to its members: helping to make people better patients for the doctors to treat. It wasn't too many years ago that CMS had a Committee on Alternative health Care Ideologies. The committee's principal weapon was education of patients and potential patients to the many facets of allopathic medicine. One of the things many physicians opposed was the idea that doctors should be teachers **AND** healers, but it was found that teaching was the only way to combat the ideologies which lured people to many unproven "cures."

CMS salutes the Hall of Life on its 25th birthday. It is doing an excellent job of educating for the physicians.



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We wish to honor the physician judged by his/her colleagues to have contributed most significantly to civic activities and the community good. All nominations must be accompanied by documentation of the physician's community services; i.e., testimonials from community leaders, honors and awards received by the nominee for outstanding community projects, testimonials from peers, friends and associates.

Address all nominations to:
Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
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Nominations must be received by Midnight, July 31, 2000, to be considered. The award will be presented at the CMS Annual Meeting in September, 2000, at the St. Regis Hotel in Aspen, CO.

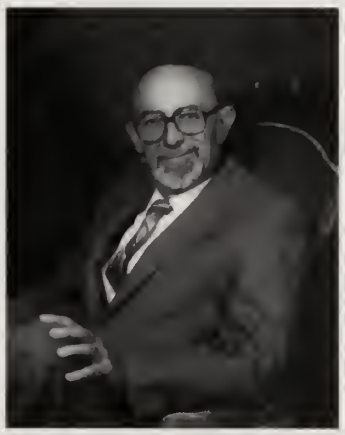
He had a deep love of family, of his church, of nature, of his fellow man, of his patients and his profession. That was David E. Bates, MD. He worked hard at being a specialist in all these areas, while being a humble servant to everything came so naturally that few (in the grand scale of things) noticed him. This is one of the finest compliments that can be given a man: he did so much for others, yet claimed little notice for himself. That was David Bates, MD, the family practitioner who came to Eaton, Colorado and settled. . . for good!

David Bates was born in Colorado Springs, then grew up in Denver where he attended East High School. He went on to the University of Colorado and received his M.D. in 1947. Eaton became his home in 1948, and he continued his practice there, except for a stint in the U. S. Army during the Korean conflict, until he retired in 1974. But retirement from practice was only so he could assume the directorship of the newly-established Family Medicine Residency Program at North Colorado Medical Center in Greeley. Dr. Bates continued at that post until his retirement in 1984.

He was one of the "founding five" (Drs. Fred Lewis, K. Mason Howard, Amilu Rothhammer, and Merlin Otteman) of the Copic Insurance Trust which became the Copic Insurance Company. He was a member of the Copic Board of Directors for ten years, during which he was very active in moulding what is today The Copic Companies. As Dr. Jerome Buckley, Copic Board Chairman and CEO, described him, "David was the original conscience of the Copic Board as well as our wisdom sage. When David spoke, everyone listened. His insights were not only always beneficial, but were rarely proven wrong." He was one who saw the injustice put upon his fellow physicians by the insurance companies of the day. He wanted to do something about it, and he did.

Dr. Bates and his wife, Betty Rae, were very much a part of their community. David had a fascination with things natural and man made. He was interested in Southwestern Indian archeology, was a student of railroading, particularly in the west, and he liked growing things. He raised seedling trees, which he and Mrs. Bates gave away. He had such a love for his community and the people in it. Eaton was principally a farming community when Dr. and Mrs. Bates settled there in 1948, you could see, literally, for miles around. His family practice touched lives for many miles in all directions. Until his retirement, most everyone in Eaton knew Dr. Bates.

His children tell how Dr. Bates taught them about his love of life and people. One cold winter night on the northern plains, just before Christmas, Dr. Bates received a call from a patient. She lived alone east of Eaton and told him she needed him to come see her; she was ill, describing symptoms. After talking with her, Dr. Bates told the four children to all come with him on a house call. They didn't know who or why, but they bundled up and went with him to see the lonely lady. One of the children asked what was wrong with her.

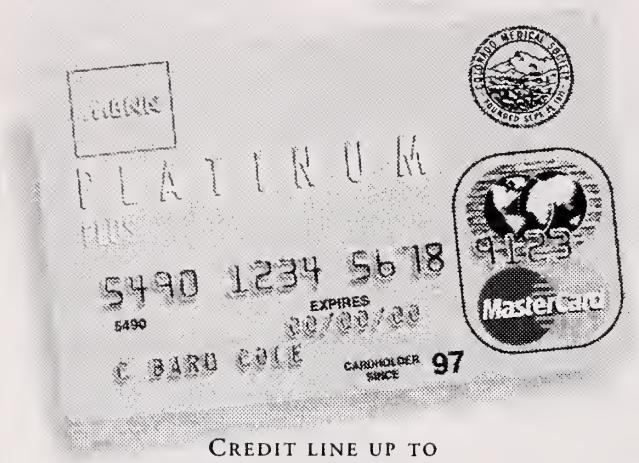


David E. Bates, MD
This portrait, made in 1984, hangs in the North Colorado Medical Center in Greeley, where Dr. Bates was the first Director of the Family Medicine Residency Program.

Dr. Bates said that the patient was just very lonely and needed to see her doctor . . . or someone.

His interest in people was almost immediately obvious when first you met him. You were his first concern. He manifested this concern in everything he did. He was easy to talk to, with an amiability about him that belied his wisdom. Dr. Bates was a superb teacher. According to some of his former students, now in practice for many years themselves, Dr. Bates was an excellent mentor and teacher. His interest in them and their success was obvious, as well.

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Please mention priority code GV4T when calling.

Please return form to: MBNA® *Platinum Plus* New Account Acceptance Center, P.O. Box 15464, Wilmington, DE 19850-5464.

Print your name as you would like it to appear on card. *Please print clearly in black or blue ink.*

GV4T
JM-949
V8

Name _____ Social Security # _____ Birth date _____ Mother's maiden name _____

Address _____ City _____ State _____ ZIP _____

Monthly housing payments $ _____ Are you: ☐ Homeowner ☐ Renter ☐ Other

Home phone (____)_____ Business phone (____)_____

Employer _____ Position _____ Years there _____ Source of other income‡ _____

Please send an additional card at no extra cost for:

_____ Relationship: _____

Your annual salary $, .

Other income‡ +$, .

Total household income $, .

‡Alimony, child support, or separate maintenance incon need not be revealed if you do not wish it considered as basis for repayment.

X _____ Date / /

MY SIGNATURE MEANS THAT I AGREE TO THE CONDITIONS APPEARING ON THIS FORM.

Please complete only if you have moved or changed employers in the last three years.

Previous Address _____ City _____ State _____ ZIP _____

Previous school or employer _____ Years there _____

Annual fee	None.
†Annual Percentage Rate (APR)	14.99% fixed for purchases.
Grace period for repayment of balance for purchases	At least 25 days, if each month, we receive payment in full of your New Balance Total by the Payment Due Date.
Method of computing the balance for purchases	Average Daily Balance (including new transactions).
Transaction fees for cash advances and fees for paying late or exceeding the credit limit	Transaction fee for Bank and ATM cash advances: 2% of each cash advance (minimum $2). Transaction fee for credit card cash advance checks: 1% of each cash advance (minimum $2, maximum $10). Late-payment fee: $25. Over-the-credit-limit fee: $25.
Transaction fee for purchases	Transaction fee for the purchase of wire transfers, money orders, bets, lottery tickets, and casino gaming chips: 2% of each such purchase (minimum $2).

The information in this application is accurate as of 12/97. The information may have changed after that date. For more current information, please call MBNA at 1-800-523-7666. TTY users, please call 1-800-833-6262.

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†–MORE APR INFORMATION–

The current promotional Annual Percentage Rate (APR) offer for cash advance checks and balance transfers made with either account is 5.9% through your first five statement closing dates, commencing the month after your account is opened. When your minimum monthly payment is not received by the close of the first complete billing cycle following its Payment Due Date, or when the promotional offer expires, whichever occurs first, the APR that will be applied to both new and outstanding cash advance balances (consisting of cash advance check and balance transfer transactions) will be 14.99%. MBNA may allocate your monthly payments to your promotional APR balance(s) before your nonpromotional APR balance(s).

–CONDITIONS–

I have read this application and everything I have stated in it is true. I authorize MBNA Amer Bank, N.A. (MBNA) to check my credit, employment history, or any other information and to report to others such information and credit experience with me. I understand that the acceptance or use of any card issued will be subject to the terms of this application and the Credit Car Agreement that will be sent with the card, and I agree to be responsible for all charges incurre according to such terms.

Unless I write to MBNA at PO Box 15342, Wilmington, DE 19850, I agree that MBNA and its affiliates may share information about me or my account for marketing and administrative purposes. I am at least 18 years of age. I consent to and authorize MBNA and its affiliates to monitor and/or record my telephone conversations with any of their representatives to bette ensure quality service. **I understand that if this credit card application is approved for an account with a credit line of less than $5,000, I will receive a Preferred Card.**

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The Lobby



Christopher J. Unrein, DO
Chairman
CMS Council on Legislation

As this Legislative session comes to a close, CMS remains very active. To date CMS has been involved in approximately 70 bills. The CMS Council on Legislation wishes to extend its' gratitude to all CMS and CMSA members who have responded to the CMS legislative alerts. Without your assistance much of what CMS has accomplished this year would not have been possible. Below are just a few of this years highlights. We will have a complete legislative wrap-up to all CMS members next month.

SB 54, Creation of Organ Donation Registry (Pascoe): Creates and maintains an electronic registry of the donors of organs and tissues.
CMS Position: Support
Status: Amended, Passed Senate. Awaiting 3rd reading in House

SB 71, Concerning Use of Moneys Received Pursuant to the Tobacco Litigation Settlement (Anderson): Specifies that moneys received by the state pursuant to the master settlement agreement arising from tobacco litigation are intended to supplement, and not supplant, any appropriations received by such programs. Requires the Dept. of Public Health & Environment to monitor programs that receive appropriations from the moneys received by the state pursuant to the tobacco litigation.
CMS Position: Support
Status: Amended, Passed Senate. Passed House, Awaiting Concurrence

SB 148, Concerning Contracts Between Health Insurance Companies and Health Care Providers (Evans): Prohibits any financial disincentives to providers based on their number of referrals.
CMS Position: Support with amendment
Status: Amended, Awaiting Governor's Signature

SB 213, Reclassification of State Agencies from Type I to Type II (Wattenberg): Reclassifies state agencies and boards from Type I to Type II, thereby eliminating physician regulation of physicians via the BME.
CMS Position: Oppose
Status: Postponed Indefinitely

HB 1023, Immunization Registry (Hagedorn): Requires the Department of Public Health to implement and maintain an electronic tracking system of the immunizations.
CMS Position: Support
Status: Amended, Passed House. Awaiting 2nd reading in the Senate

HB 1063, Tax Credits for Health Care Professionals Practicing in Rural Areas (Young): Defines a "health care professional shortage area." Provides for income tax credits at an amount equal to a set percentage of the state income tax liability of the physician, physician assistant or nurse who practices in a shortage area.
CMS Position: Support
Status: Amended, Passed House. Passed Senate

HB 1076, Prenatal Care for Undocumented Women (Tool): Directs the state to provide prenatal care for undocumented aliens who are eligible for emergency Medicaid through contracts with managed care companies.
CMS Position: Support, as amended
Status: Amended, Passed House. Passed Senate HEWI, Referred to Appropriations

HB 1078, Penalties for False Medicaid Claims (Leyba): Authorizes a civil action against providers who present false records, statements, or claims.
CMS Position: Support, with amendment
Status: Amendments unacceptable to CMS, Bill deemed lost

HB 1104, Tax Credits for Health Care (T. Williams): Allows Colorado residents to claim tax credits for amounts paid for health benefit plans.
CMS Position: Support
Status: Amended, Passed House. Awaiting 2nd reading in Senate

HJR 1033, Concerning Opposition to the Use of Marijuana for Medicinal Purposes (Spence): Opposes the effort to mandate in the Constitution of Colorado that marijuana be described as medicine or that the possession & use be decriminalized for medicinal purposes.
CMS Position: Support
Status: Awaiting 3rd reading.

A full recap will be published in the June issue of ***Colorado Medicine.***

Safe Harbors Established by the Office of the Inspector General With Respect to the Federal Anti-kickback Statute.

by Anne Cox
*Attorney at Law**

There are now a total of 23 "safe harbors" published by the HHS/OIG to provide guidance to physicians. Safe harbors immunize certain payment and business practices from criminal and civil prosecution under the anti-kickback statute. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor. Failure to comply with a safe harbor provision does not mean that an arrangement is per se illegal. Instead, arrangements that do not comply with a safe harbor must be analyzed on a case-by-case basis for compliance with the anti-kickback statute. To achieve greater certainty with respect to an arrangement that does not fall within a safe harbor, the OIG will issue "Advisory Opinions" but, in practice, the process is too tedious and time-consuming to be very practical.

Eleven safe harbors were finalized in 1991, immunizing the following types of business or payment practices: investments in large publicly held health care companies and investments in small health care joint ventures; space rental; equipment rental; personal services and management contracts; sales of retiring physicians' practices to other physicians; referral services; warranties; discounts; employee compensation; group purchasing organizations; and waivers of Medicare Part A inpatient cost-sharing amounts. The 1992 "interim final" safe harbors, which were finalized in 1996, addressed the following practices in managed care settings: increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans to beneficiaries; and price reductions offered to health plans by providers.

The new safe harbors address the following areas: investments in underserved areas; practitioner recruitment in underserved areas; obstetrical malpractice insurance subsidies for underserved areas; sales of practices to hospitals in underserved areas; investments in ambulatory surgical centers; investments in group practices; referral arrangements for specialty services; and cooperative hospital service organizations.

The new "Final Rule" published as *42 CFR Part 1001* on November 19, 1999 "clarifies" six of the original safe harbors and explains the establishment of eight new ones. A brief discussion about each of those follows.

1. *Clarification to the Investment Interests Safe Harbor* - Referrals to large public entities in which a provider has invested will qualify for a safe harbor exception if the entity has revenues or assets in health care goods or services greater than $50 Million. Furthermore, the provider must acquire his interest at a price available to the general public and there must be no restrictions on the securities that do not exist for the general public. To invest in a smaller company, the entity must derive no more than 40% of its revenues from "tainted" individuals who have an ownership interest in the entity.
2. *Clarification to the Space and Equipment Rental Safe Harbors* - These safe harbors protect certain contracts for space rental, equipment rental and for personal services and management contracts, with all of them requiring that the contract be for a minimum of one year. The clarification requires that these contracts not permit early termination "without cause", a provision the OIG views as inviting kickbacks for referral volume.
3. *Clarification to the Personal Services and Management Contracts Safe Harbor* - Once again, the OIG clarifies this safe harbor by eliminating "without cause" terminations of the contract after less than one year.
4. *Clarification to the Referral Services Safe Harbor* - To meet this safe harbor, a referral service must include any provider who meets the criteria for participation. The Clarification provides that varying fees may not be charged by the referral service, based on referral patterns.
5. *New Safe Harbor for Investments in Ambulatory Surgical Centers* - Surgeons, physicians and hospi-

(Continued on following page)

tals may have an ownership interest in ASCs so long as (1) the ASC is Medicare certified; (2) the ASC's operating and recovery room space are dedicated exclusively to the ASC; (3) all patients referred to the ASC by an investor must receive information about the investor's interest in the ASC; and (4) all ancillary services available be directly related to primary procedures performed at the ASC and none of those may be billed separately to Medicare. Physician investors in ASCs must derive at least 1/3 of their income in the last 12 months from the performance of procedures that require an ASC or hospital surgical setting.

6. *New Safe Harbor for Investments in Group Practices* - A physician may derive income from an equity interest in a group practice so long as the interest is in the group practice itself, and not in a subdivision of the group. Furthermore, the group itself must satisfy requirements of a group under Stark and revenues from ancillary services must be derived from "in-office ancillary services." The group practice must be "unified" and the compensation/ expense system must not be based on satellite offices operated as if they were separate "profit centers."

7. *New Safe Harbor for Investments in Health Care Entities in Underserved Areas* - Investments in Medically Underserved Areas ("MUA") as designated by the Health Resources and Services Administration enjoy new recognition that such areas face unique recruitment and retention problems. Now, 100% of referrals may come from "tainted" providers, but non-referral source investors must hold 50% of the investment interests.

8. *New Safe Harbor for Practitioner Recruitment in Underserved Areas* - Hospitals may engage in physician recruitment activities to induce the relocation of physicians to a Health Professional Shortage Area (HPSA) so long as at least 75% of the physician's new practice revenue be generated from patients residing in a HPSA or MUA. The recruitment incentives must be memorialized in a written instrument, may not be for more than 3 years, may not include referral requirements and may not restrict the practitioner from holding staff privileges in other hospitals.

9. *New Safe Harbor for Subsidies for Obstetrical Malpractice Insurance in MUAs* - This safe harbor protects malpractice subsidies for obstetrical care paid by a hospital or other entity where such payment is for the benefit of an independent practitioner (including a certified nurse-midwife) who engages in obstetrical practice as a routine part of her medical practice in a primary care HPSA. At least 75% of the practitioner's obstetrical patients must reside in an MUA.

10. *New Safe Harbor for Sales of Physician Practices to Hospitals Where Practices are in HPSA* - In a HPSA, a physician practice may be sold to a hospital provided (1) the sale must be completed in 3 years; (2) after completion of the sale, the practitioner will no longer be in a position to make referrals to the hospital; (3) the physician's practice must be located in a HPSA for the practitioner's specialty area; and (4) the hospital must engage in good faith efforts to recruit a new practitioner.

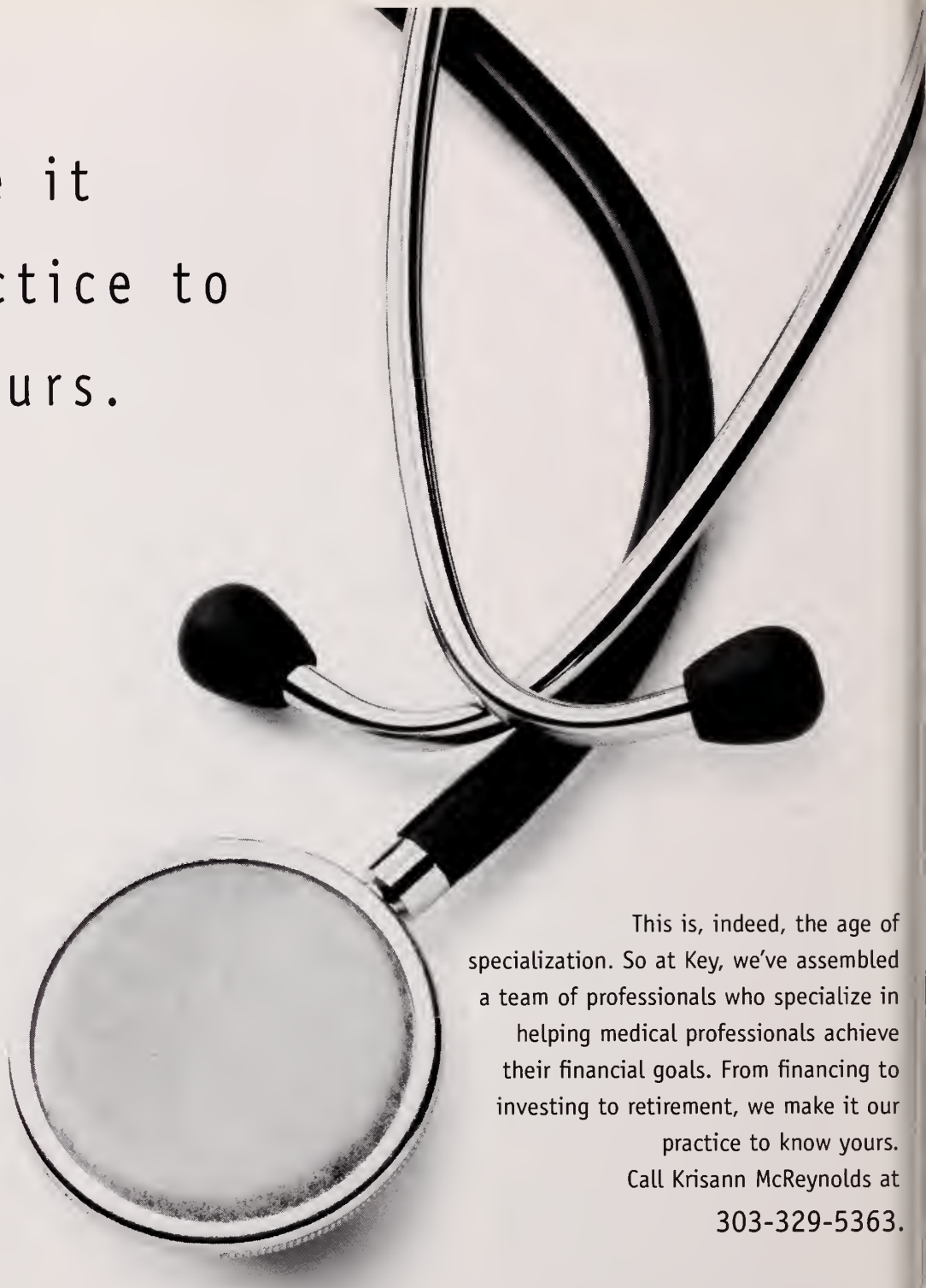
11. *New Safe Harbor for Specialty Referral Arrangements Between Providers* - This safe harbor excludes from the purview of the anti-kickback law any "exchange of value" among individuals where one party "agrees to refer a patient to another party for the provision of a specialty service" in return for an agreement that the other party will "refer that patient back at a mutually agreed upon time" as long as certain requirements are met. In particular, it is required that the time and circumstance for the referral back be clinically appropriate and that the service for which the referral is made not be within the expertise of the referring individual. Neither may receive any payment from each other for the referral nor share or split a global fee in connection with the referred patients. Finally, unless the parties belong to the same group practice, the only "exchange of value" is the remuneration the respective parties receive from either third party payers or the patient for the services furnished to the patient.

12. *New Safe Harbor for Cooperative Hospital Services Organizations* - Most CHSOs that qualify under Section 501(c)(3) will be permitted to make payments to the CHSO so long as the payment is for the bona fide operating expenses of the CHSO.

The clarifications of existing safe harbors and the descriptions of the new safe harbors are all very laborious and technical. The foregoing explanations are so brief as not to be reliable for decision-making purposes. Any arrangement designed to fall within the safe harbor needs thorough analysis to ensure that all the requirements are met. Otherwise, there is no assurance the OIG will recognize the arrangement as an exception to the anti-kickback law.

* Anne Cox is an attorney and a member of the Legal Department, Copic Companies. Ms. Cox is also in private practice with the Law Offices of George Dikeou.

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COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



New Help from Copic to Reduce Human Resources Risks

You might think a malpractice claim is the only significant risk you face in your practice. But you might want to think about what can happen if you make a mistake not with a patient, but with an employee. Employment-related lawsuits in Colorado have resulted in verdicts exceeding six figures. According to Myron L. Treber, Vice President of Copic Insurance Company's Management Advisory Services (MAS) department, in any given month a medical practice is just as likely to have to deal with a potentially costly employment or human resources issue as it is a disgruntled patient.

Our insured physicians often desire help with this critical aspect of their practices. In fact, Myron routinely responds to several calls each week from practices looking for assistance with some facet of human resources management. However, it wasn't until we began offering our new "Risky Practices" workshop in March that we learned exactly how eager physician practices are to have this critical information.

"Risky Practices" is a full-day workshop designed to give practice managers, physicians, and others responsible for human resources management the knowledge and tools they need to reduce the risks that accompany this critical function. Attendees come away from the session with essential information, easy-to-implement tools, and valuable resource materials that give core competence in the most important areas of personnel management. Every attendee receives a complementary copy of a comprehensive practice manual containing: a complete model employee handbook; a salary report detailing wages for all typical medical office staff positions in Colorado; a summary of pertinent federal and state employment law; detailed instructions for setting up and maintaining personnel files; complete model job descriptions for numerous common staff positions; and samples of administrative forms (e.g., absence approval request, orientation checklist, etc.).

When we launched "Risky Practices" in March, we had originally planned for three workshops, each with 20 participants. By the end of April, we had conducted four workshops with more than 30 registrants each. Driven by demand from our insured practices, we have scheduled four additional workshops through June... and we've had requests for workshops in Pueblo, Fort Collins, and northeastern Colorado. (See http://www.copic.com/seminars/risky%20practices.htm for more information.) You have spoken, and we have listened!

I am also pleased to announce that Copic is committed to expanding our services in this important area. Our plan is to offer services on a bundled or unbundled basis depending on your needs and preferences. Services will range from project work (such as assistance in writing job descriptions) all the way up to establishing a complete human resources function. We will also have a human resources professional available to answer employment-related questions. The intent is to help reduce the time and money you spend on human resource management so you can increase the time you spend developing your practice. Myron is developing a pilot program to provide these services, and we expect to have the program ready for implementation sometime later this year. (Watch for updates in the Copic Topics newsletter and in this column.) In the meantime, if you have any questions regarding human resources please feel free to give Myron a call at (720) 858-6178.

CMS Online

Latest news from Colorado's largest physician organization:

http://www.cms.org

CMS OnLine web page.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

The Colorado Physician Network (CPN) has recently passed its fifth birthday. Like a five-year-old child, it can look with pride at the milestones it has passed. The pandemic of infant mortality has been avoided. Hopefully the Terrible Two's are well behind us. Sitting up, standing alone, first steps, bending without falling, standing on one foot, and agility in moving fonrvard and backward are of historical note, and it is now possible to run, climb and "swing."

Long gone are the limitations of cooing and crying, of monosyllabic verbage, and constricted vocabulary, as a five-year-old speaks in complete sentences clearly enough for strangers to understand, and perceives the concepts of "same" and "different." Initially totally self-focused and dependent, followed by gradual awareness of others with imitational and then separational social maturation, the five-year-old should have increasing independence, awareness of the rules, and the ability to negotiate solutions to conflicts. Physical growth is multiples of birth size, yet still a fraction of what is anticipated in future years.

At age five, we are pleased not only to have merely survived, but to be on the threshold of increasing community awareness and involvement. With this comes the responsibility of exponential learning, increased self-sufficiency, risks of confrontations with bullies, scraped knees and bloody noses, and protecting our lunch money. We are yet far from grown up, with many lessons to be learned, and confident, mature stability a distant but achievable goal.

So, Happy Fifth Birthday to CPN! Let us celebrate it for what it is, and embrace it for what is yet to come!

CMS Online

http://www.cms.org

CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the Annual Meeting of the House of Delegates in Aspen, September 22, 2000. We request nominations for the following:

- American Medical Association (AMA) Delegates
- AMA Alternate Delegate
- Colorado Medical Society Speaker of the House of Delegates
- Vice-Speaker of the House of Delegates
- CMS President-elect

Dr. Richert Quinn is running for re-election as AMA Delegate.

Dr. Steve Thorson, is running for re-election as AMA Alternate Delegate.

Dr. Robert McCartney does not plan to run for re-election as AMA Alternate Delegate.

Dr. Jack Berry is a candidate for election as AMA Alternate Delegate.

Dr. Louise McDonald is a candidate for President-elect of CMS.

Dr. Sherri Laubach is running for election as Speaker of the CMS House of Delegates.

There is currently no nomination for the post of vice-speaker.

If you are interested in being a candidate for any of the above offices, please submit your name and a current resume' to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550. If you have any questions, contact either Sandra Maloney or Debra Jones at 720-859-1001 or 1-800-654-5653.

Mesa County Medical Society Alliance Recognized

American Medical Association Alliance selects five outstanding public health projects nationwide.

Initiated in 1989 by the AMA Alliance, the Health Awareness Promotion (HAP) Awards recognize excellence in the health programs and projects of county Alliances throughout the nation. Five county Alliances are recognized annually for their work in one of five categories: community service, education and awareness, fund-raising (recognizes effective planning and implementation, not amount of money raised), SAVE and SAVE Today (support of the Stop America's Violence Everywhere program) and Resident Physician and Medical Student Spouses (efforts of these individuals in any of the above categories).



Debra Horwitz (l) and Karen Millbank Ellinwood, co-Chairs for "A Chance To Celebrate"



JoAnne O'Fallon of the Center for Children (with check), and Louise Sammons, MCMSA President.



Honorary Chairperson Marilyn Van Derbur, former Miss America, with Stella Shanks (l), Immediate Past President, and Joyce Wilson, current President of the CMS Alliance.

Mesa County Medical Society Alliance (MCMSA) won the HAP Award for their efforts in the fund-raising category.

The Alliance organized a four-component event consisting of a day long Home and Garden Tour, a public speaking engagement by an Honorary Chair-person followed by a VIP reception, a community raffle and an Alliance publication of a community desk calendar. The project was a complex undertaking, requiring 15 months of planning and 12 working committees.

"A Chance to Celebrate" was the name of the project and a local children's advocacy center (Center for Children) was chosen as its beneficiary. The Center's purpose is to reduce the trauma of investigations of child sexual abuse and to promote justice and healing.

The Honorary Chairperson, former Miss America, Marilyn Van Derbur, addressed a community group. Having the premier spokesperson for childhood incest recovery deliver an address was certainly a highlight of the project. Co-sponsored by their Alliance, Medical Society and the State College's Lectures Committee, the Alliance was able to offer this as a free public event. The occasion received tremendous media coverage from which they were able to springboard further attention to the issue of child abuse as well as advertise their Home Tour, which took place two days later.

Congratulations to the Mesa County Medical Society Alliance!



John L. Lightburn, MD
Historian
Colorado Medical Society

Continuing Our Saga Of The "40s"

As World War II wore on and the outlook for the Allies and the United States became more favorable, there was less anxiety on the home front, but we remained united in our effort to support our fighting men overseas.



Edward R. Mugrage, MD

The CMS continued to support the physicians who were in the armed forces. At the same time it supported the physicians on the home front who were coping with shortages, rationing, price controls and increasingly busy practices. Even though winning the war was the primary concern of the Federal Government, New York's Senator Wagner was still promoting his plan for universal compulsary health insurance. Many in the CMS such as George Lingenfelter and Bradford Murphy felt it was their responsibility to stop Wagner and his cronies so that the men in the service could come home to a practice free of governmental interference.

Following George Lingenfelter's presidency, the House of Delegates elected Edward R. Mugrage to be our 74th president. He was born in 1885 in Leadville, the son of a pioneer physician. As a young boy, he had a severe case of Scarlet Fever followed by bilateral mastoiditis. Subsequent mastoidectothies left him with a severe hearing loss. In spite of this handicap, he did well in school and majored in chemistry at the University of Denver. After working a few years as chief chemist for the Great Western Sugar Co., he entered the Denver and Gross College of Medicine in 1909. The two schools merged, and he received his M.D. from the School of Medicine at the University of Colorado in 1913. After an internship at Denver's Mercy Hospital, Dr. Mugrage was appointed Instructor in Pathology at the School of Medicine. In 1920, he was seriously ill with encephalitis which left him with post-encephalitic Parkinson's Disease with a marked intention tremor of his extremities and his voice. But Ed's devotion to medicine and his students prevailed, and he was a brilliant teacher in spite of his handicaps.



George A. Unfug, MD

He was professor and head of Clinical Pathology and Public Health for many years and was known as "Uncle Ed," truly beloved by all his students. In his presidential address, he did not follow the line of this predecessors with a call to resist the threat of socialized medicine. He knew that there had been many complaints by physicians in private practice about the medical school and the policy of admitting paying patients to its teaching hospital, Colorado General. He wanted to mitigate the "town and gown" conflict. He asked his colleagues in CMS to recognize that the medical profession was an essential element in medical education, that the medical school could not do it alone without their wisdom gained from years af clinical practice. His plea was for collegial collaboration rather than competitive confrontation. This gentle, kindly man was the right man to bring about the healing.

When George A. Unfug was asked if he would accept tha nomination for CMS presidency, he thought he was too young for the job. Born in Walsenburg in 1900, he had learned fiom his businessman father the rewards of active involvement in politics and community. He graduated from the University of Colorado School of Medicine in 1926, just two years after the school had moved into its new building and hospital at 9th and Colorado Boulevard. He was a gencral practitioner in Pueblo for five years before coming to Denver for a preceptorship in Radiology under Doctors Stephenson and Allen. This

tall, gangly Lincolnesque and energetic man became a dominant force in the medical and civic affairs of Pueblo. He was chairman of the Republican county committee, engaged in a busy and successful radiological practice and an aggressive defendcr of a free doctor/patient relationship unhampered by third party payers. At the annual meeting of the state medical society at Glenwood Springs in1940 he was violently opposed to a state wide prepaid medical service plan.



Archer C.Sudan, MD

But in his presidential address in September, 1945, just five weeks after the end of World War II, Dr. Unfug presented an ambitious plan for the CMS, a plan to provide prepaid medical care to the whole state and perhaps eventually expanding it to include the adjoining states of Wyoming, Utah and New Mexico. The plan would cover the elderly, self employed, medically indigent. the returning veterans as well as the employed.

It would be voluntary, and, most importantly, it would be locally controlled by a board of directors consisting of physicians chosen by the CMS House of Delegates! Admitting that he had changed, he said he was fortunate to still have a young mind that was flexible. He then quoted Emerson's famous aphorism, "Foolish consistency is the hobgoblin of little minds." He liked the "Michigan Plan" and reasoned that the best way to oppose the Washington planners was to present a better plan. His creative leadership prepared the CMS for its expanded role in the amazing post war era.

With the end of the war in August, 1945, 16 million men were demobilized with a carefully devised plan. After World War I, there was no plan. The 5 million soldiers in World War I were simply discharged in 1919 with $60.00, a train ticket home and the promise of an $800.00 bonus to be paid fifteen years later, in 1931, unemployed veterans marched on Waghington demanding the promised bonus, an event that sealed the defeat of Herbert Hoover. In contrast, the Congress, pushed by the American Legion in 1943 and 1944, passed the The Servicemen's Readjustment Act of 1944, known as the "GI Bill of Rights". There were four main provisions of the Act: 1. Readjustment allowances; 2. Educational opportunities in colleges and universities; 3. Vocational education; 4. Low interest loans to purchase homes, farms or business. The impact of this legislation was profound. For example, in 1940 prior to the G.I. Bill, approximately 160,000 received college degrees. By 1950, the graduating class numbered 500,000. By 1947, 1,164,000 veterans registered for college on the G.I. Bill accounting for 49% of all college enrollment. Over time, 2.2 million veterans went to college. New medical schools were established and established schools enlarged their classes. The University of Colorado increase the size of the undergaduate class from 53 to 125. Utah and New Mexico opened four year medical colleges.

In tbe midst of these exciting changes, Archer C. Sudan, a Kremmling general practitioner became the 76th President of the CMS. T)r. Sudan's administration featured a sweeping change in our public relations program under a new Code of Coopeeration with the news media, the formation of the Board of Supervisors (now the Grievance committee) and wide expansion of Blue Shield that had been promoted by his predecessor, Dr. Unfug.

It was said that Archie was not popular with the AMA hierarchy, but the AMA House of Delegates voted him the highest honor ever awarded a Family Physician, the first gold medal as the "General Practitioner of the Year". Overnight, his broad grin and life history were on newspaper front pages and in national news magazines. "He's the medical story of the year," said one science writer. In his presidential address, he said the Governmefnt would do well to leave medical practice alone and devote its energies to public health pursuits such as sanitation and disease prevention.

Dr. Sudan was born on a South Dakota farm in 1894, earned his way through the University of Chicago by working as a barber and a summer farm worker to complete studies for a B.S. Then came World War I in which he served as an Army machinegunner. Returning to Chicago, he earned his M.S. before winning a scholarship to Rush Medical Collge. He had an outstanding academic record and after graduation he was offered a faculty position under his mentor, Dr. A. J. Carlson. His promising career in medical research and teaching was interrupted by a fishing vacation to Middle Park, Colorado, where he discovered the nearest physician to Kremmling was 57 miles. When young Archie Sudan saw the medical needs of this community, he wired Chicago for a leave of absence, and a year later wired his resignation. The Basic Soience examination did not scare him. For the next 21 years, he was the most beloved man in Middle Park, ministering to a mountainous, rural area larger than Rhode Island.

Equally dedicated to his profession and the CMS as Archie Sudan, John Bouslog, a Denver Radiologist, became the 77th president of the CMS. After completing his internship in 1917, he became almost constantly involved in organized medicine. It seemed like that was his mission. After a brief time in general practice in Boulder, he moved to Denver for a preceptorship in Radiology and remained in Denver

as a successful radiologist until 1965.

Here are a few of Dr. Bouslog's biggest jobs: CMS constitutional secretary, 12 years, three as acting Executive Secretary while Harvey Sethman was in the Armed Services, Clinical Professor of Radiology at the University of Colorado for 12 years; four years (one as Chairman) on the Board of Chancellors, and later president of the American College of Radiology; co-founder of Colorado's Blue Shield and its Treasurer for seven years; Board of Directors of the American Cancer Society for six years; CMS leader in a dozen legislative battles. The list goes on and on.



John Bouslog, MD

As president of CMS, he was eager to improve the image of the society and was proud of his work on the "Code of Cooperation" with the news media. He was a shining example of the ethical, dedicated physician. In his Presidential address, he tore into lax ethics, overcharging, apathy and laziness. He expected from each member of the society the same degree of loyalty and dedioation to the profession that he had given. A truly admirable man.

There was another attribute that provided him with some degree of notoriety. Friends who shared hotel rooms with presidents on trips to meetings had electcd John Bouslog and Archie Sudan as "Co-World-Champions of Snoring". All ageed that Sudan's was the loudest and Bouslog's the most fearsome -- he would stop breathing so long that anyone would think he had died, but eventually an implosive and loud intake would start the cycle all over again. Perhaps we could rename sleep apnea the Bouslog Syndrome.



Casper F. Hegner, MD

Casper F. Hegner became our 78th President in1948. Dr. Hegnwer was a brilliant su rgeon; some called him a perfectionist. He completed four years of medical college in three years; he received a faculty award for outstanding student in pathology and was graduated near the top of his class at Ohio Medical College in Cincinnati. After internship in 1903 and a year's postgraduate study in Europe, he became one of the bright young stars in surgery and pathology. Several Ohio firsts were credited to hm, including frozen section diagnosis and Matas aneurysmorrhaphy. All this by his early 30s. But by 1913, this energetic young surgeon was seriously ill with pulmolnary tuberculosis and, following the advice of his physician, came to Colorado to "chase the cure". After regaining his health he resumed practice and joined the faculty of the University of Colorado. By 1936 he had advanced to Professor of Surgery and Head of the Department of Surgery, a position he held until 1941. He drove himself mercilessly with the oft repeated phrase, "I should have done better." And he expected perfection from his colleagues, a trait that alienated many.

His Presidential address exemplified his drive for perfection. It was an eloquent call for higher standards of care and education, greater devotion to duty and loyalty to the CMS, increased dedication to give the patient the very best. Here is how he started his address: "The prime objective of the practice of medicine in all of its many branches is to always render the best possible service to all afflicted people everywhere. The immediate purpose is to CURE, failing that to restore, promptly, to as near the normal as it is humanly possible, and last but by far not the least, to alleviate suffering and to oomfort always."

Midway in his term as president, he suffered a major myocardial infarction. The Board of Trustees appointed Vice-president Lester Ward as "Acting President" during Dr. Hegner's illness. His recovery was slow, and his physician begged him to resign. But this rigidly, self-disciplined thoracic surgeon would not neglect his duty or his commitment. He insisted that CMS staff members report to his bedside daily. When he sometimes reversed a decision made by Acting President Ward, the Chairman of the Board of Trustees had to arbitrate. It was a tough go for both Dr. Hegner and the CMS, but both survived. Casper Hegner lived till he was 81.

The House of Delegates elected a very different man to be our 79th President. They chose a man who grew up in Broken Bow, Nebraska and after finishing high scbool played professional baseball and taught in a rural school while trying to decide what he was going to do wilh the rest of his life. Should he study law or medicine? It was our good fortune that Fred A. Humphreys decided to study medicine, receiving his M.D. from the University of Nebraslra in 1921. He started his general pramice in Fort Collins in 1925 after a brief time in Wellington, a small rural community east of Fort Collins, True to his rural heritage, he was an active and effective advocate for rural Health care in the CMS, the AMA and the American Academy of General Practice. As busy as he was with his large practice and many offices in

(Continued on following page)

organized medicine, he still had time for tennis, sometimes competing in tournaments. In the evening he enjoyed contract bridge with his wife and friends.



Fred A. Humphreys , MD

Atter a serious talk on the responsibilities of the CMS to its members and the need for collaboration between members and the CMS, Dr. Humphreys ended his presidential address with a quote from a book, *"In a Chinese Garden"* in which there was a description of a brass plate on which was engraved the following: "Enjoy yourself! It is later than you think." He then quoted from the forward of this book, "This seems the time to remind many men and women that they will have more years, and happier ones, to do good for others if they start right now to do something for themselves; to go places and do things they have looked forward to for years; to give those who love them the happiness of seeing them enjoy the rewards. ..; to replace competition with a little bit of contemplation..." He then ended by saying, that doctors have been too busy caring for others and ignoring their own health.

Was he talking to his friend, Casper Hegner? Is he talking to us?

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If you want to swim with the sharks you have become a shark yourself

NOTE:

The Colorado Foundation for Medical Care (CFMC) has always counted on the experience of physicians to assist in our quality improvement projects. During our recent outreach to hospitals across Colorado, Randall Marsh, MD, a cardiologist practicing in Greeley, related his hospital's experience auditing practice patterns for acute myocardial infarction (AMI) management.

Here is Dr. Marsh's account of the audit process with the hope that it may help others.

CFMC has asked me to share our experience in Greeley auditing AMI cases. We first got interested in this when the CCP[1] audited our AMI management in 1996. After receiving our data we decided to "audit the auditors" by reviewing the same 100 charts the CCP had audited in our institution. We found that CCP had significant problems with its audits. We also discovered, however, that we were not as good as we thought we were. It was this rude awakening that pushed us into the audit business.

The system we have installed over the past four years allows us to audit virtually every AMI while the patient is still in the hospital. We have learned to do this without new personnel but it has not been easy. Before you commit to quality improvement, you need to know up front that data collection and entry take significant time.

The hospital and cardiologists work cooperatively to capture all possible cases, and the hospital has contracted me to spend 15 to 20 minutes daily coordinating the project. There is also a cardiac nurse (Molly Wright, R.N.) that has added to her duties the role of auditor and data entry. The hospital purchased a computer which resides on the step-down ward for AMIs so that our data entry point is located with the patients.

Has it been worth it? Absolutely. We have clearly altered the practice patterns of all the cardiologists in this institution. In fact, adherence to proven treatment modalities is now higher than 90%, and in most cases, higher than 95%. How did we get the other people to comply? We used existing weekly cardiology conferences to talk repetitively about treatment guidelines and continually report the ongoing audit results.

It is clear that the future of any institution is going to depend on its ability to demonstrate its quality of care. It is no longer enough to assume that your quality is self evident. You are going to have to be able to demonstrate at a moment's notice the performance of care in your institution. As an example, United Healthcare recently sent us a ten-page questionnaire with virtually the same questions as our own audit. Because of our ongoing system, not only were we able to provide the insurance carrier with the snapshot they requested, we were able to provide three years of longitudinal data. I fully expect other groups, including the Health Care Financing Administration, to request these data as time goes on.

The hardest part has been convincing everyone involved, not just the cardiologists, that we are not out to "get" anybody. By moving slowly, and ensuring both patient and physician confidentiality, we were able to gain everyone's confidence. Our goal has always been to improve performance of the institution as a whole, and we have succeeded. All the physicians now have enough experience with the audit that true mistakes are rare. While it is probably no longer necessary to audit all the cases, the system in place requires so little effort that we continue to do so.

As a result of this experience, we have now attempting to audit both the inpatient and outpatient management of congestive heart failure (CHF) in collaboration with CFMC and several practices here in Greeley. CFMC is also working with several cardiology, family practice, and internal medicine practices in Denver and the rural Northeast Colorado to improve the treatment of CHF.

(Continued)

Sharks *(Continued)*

Finally, I would like to thank CFMC. Once we realized that self-auditing was truly in our best interest, it became clear that CFMC was here to help us. Over the past few years, they have worked closely with this institution and we continue to talk frequently about on-going endeavors. I am thankful for their presence and continue to work with them on a regular basis. I would recommend that you give them a call because what they are trying to do is to improve care. Clearly, collaboration with CFMC has made a difference.

REFERENCES:

[1] CCP: Cooperative Cardiovascular Project, a HCFA-directed national quality improvement effort, where thousands of hospitals records of acute myocardial infarction cases were abstracted across the nation. The Colorado effort was directed by CFMC.

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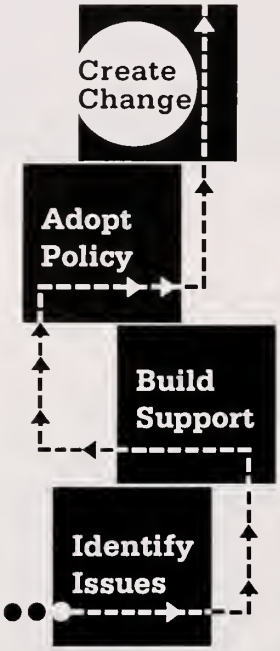
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- Persuade the AMA to **adopt policy** that will further the needs and concerns of medical staffs; so as to
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- status of legislative initiatives
- medical errors
- the impact of MCO insolvency on physician practice

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at **omss@ama-assn.org**

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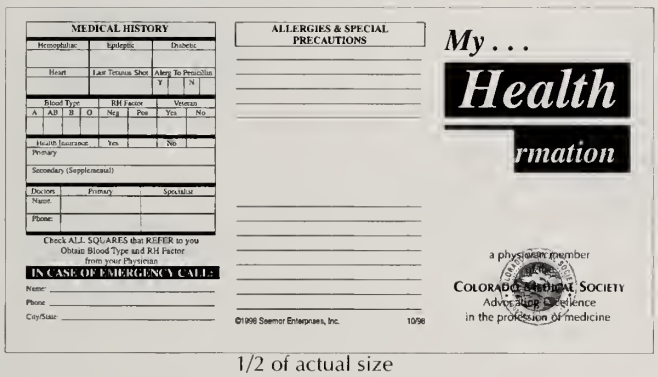
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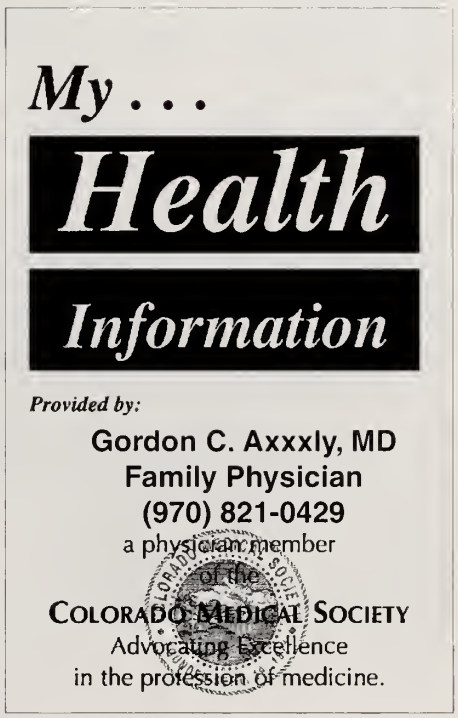
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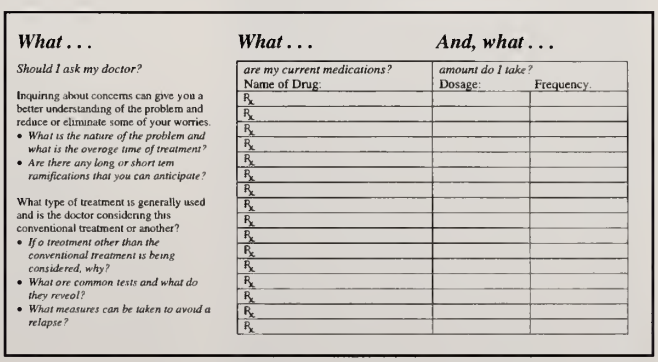
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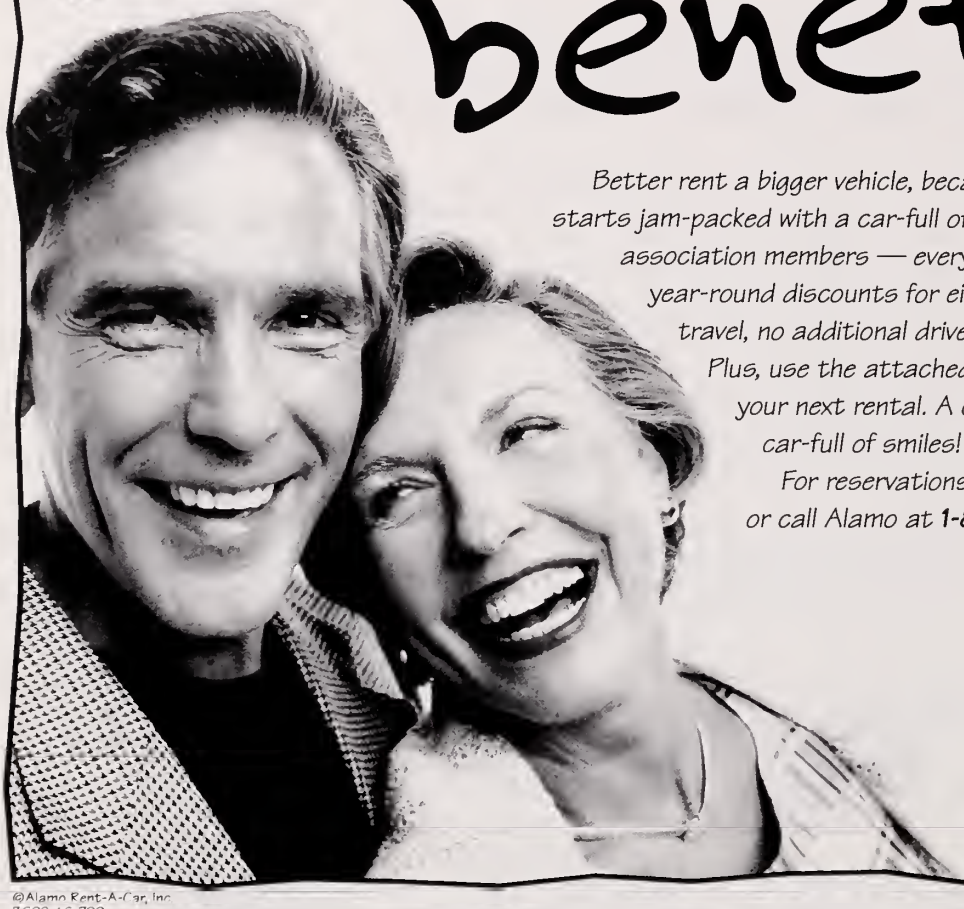
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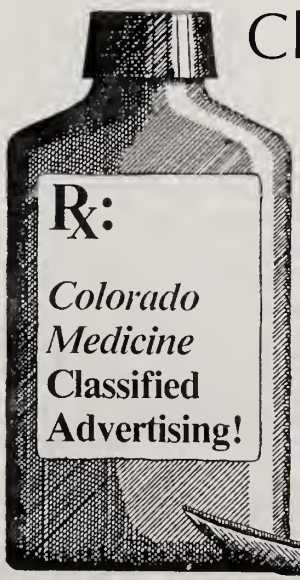
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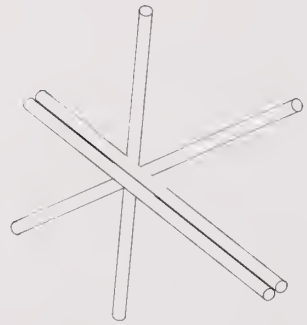
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor



My thinking is always challenged when I stop to consider what the anthropologists down the road 1000 years will find when they start "digs" in our American soil. But this latest development I am about to report will be the strangest yet.

I have been an avid reader of the National Geographic magazine for more years than my wife likes to recall (I won't let her dispose of any of the back issues), and I am fascinated by what archeologists, anthropologists, explorers and excavators dig up, representative of humankind. There are so many awe-inspiring creations of ancient man I just have a hard time believing that we call ourselves so advanced. Look back at the many engineering feats which were constructed even preceding anno Domini. I recently saw a special on the "Great Wall" of China which was started in about 450 B.C. The construction continued for hundreds of years as the engineering skills changed and as the necessities of defense grew. One of the comparisons made during the program was that we all think of the Pyramids of Giza as tremendous developments, the workers dragging the stones for miles and placing them in the pyramids. How they did this, no one has yet figured out. But, when you think of the Great Wall of China, think of this same job, not in some sandy flat spot, with no vegetation or precipices, **and** going on for hundreds of years. That project also covered about 4,000 miles in the most difficult terrain. The Great Wall becomes the most awesome feat of man in all recorded history.

We see the reports of Spanish galleons being discovered on the ocean floor all over the globe, sunk as they transported booty from their various conquests. Gold coins, goblets, silver jewelry and adornments brought up from the sea, as new and as shiny as if it were just minted yesterday.

Here, in Colorado, we get excited (at least, I do) when someone makes some small discovery of a building, a tool, a piece of money, signs of a way of life, from something no older than 150-200 years. I live a lot of my time in the mountains where there was substantial mining in the 1800s. I often find traces of the miner's life and hardships, and it still excite me to imagine who last held this utensil or tool or personal item. I remember once when I was in Scotland and I went into a Norman ruin which was obviously built (about 3,000 years ago) for a short person. I got so excited about this that I hardly noticed the pain (the first day) from where I walloped my head on one of the low stone doorways. (The second day I felt differently).

What we discover is really not old at all, on the scale of the Great Wall or the Pyramids. What we see in all these varying things uncovered or dug up is that the human has walked much the same path since his evolution or creation: he struggles for survival, building shelters, seeking food, practicing greed and avarice and generally leaving his human detritus for his descendants to dig up. Until now! We are, however, a caring kind, and the act of donating our vital organs and other healthy body parts upon our death has become a common practice. . . maybe a little too common.

Medical researchers have discovered that bone marrow is a vital healing substance, and donors are sought out. This creates a problem for our society: when the donor's body is embalmed for that great "self-storage" plot called the "cemetery," there is no bone mass around which to keep the body intact. What the morticians have taken to doing is going to the building supply store and buying that indestructible material known as "PVC" (polyvinyl chloride). Take the bone out - put the pvc in. PVC comes in all size tubing, and with all angles of joints which can be affixed to the tube. You may just run into some future shortage of repair materials for your sprinkler system.

Can't you just imagine what the anthropologists will think when they dig up the first of these PVC-reinforced human remains?

"Look, Charles! Here's one with a tubular skeletal structure. How curious. Do you suppose this predates the anthropoid?"

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President 1999-2000
Colorado Medical Society

I'm sure no one was more surprised and angry than I, when a headline several months ago blared: "Malpractice Kills Thousands". My immediate response was to fire off a letter to the editor regarding the accurate definition of malpractice (includes injury resulting from negligence) and accurate reporting. That letter was of course not published. A more reasoned response to the Institute of Medicine's (IOM) report on medical error entitled "To Err is Human" has been to spend the last several months learning about these issues before writing about them.

A meeting in Baltimore last month entitled, "Medical Errors" and sponsored by PIAA and JCAHO was particularly helpful to me in bringing these issues into perspective. Likewise have been various journal articles which have focused on the data reported by the IOM, how it was gathered and what it really means. We all understand and have been aware that medical errors resulting in harm and even death to patients do occur though clearly at some rate lower than that implied by much of the lay media. I know of no physician who would say no errors occur, and I also know of no physician who would say we should not do everything systematically possible to reduce harm to patients.

After all we are indeed human and functioning in an evermore complex and difficult medical system. The title of the IOM's report in itself reflects understanding of that circumstance. To look for solutions, then, we must first examine what the problem really is and quantify the extent of its components.

It turns out in 99% of the medical errors cited by the report, system failures were responsible for the harm to the patients, and it in most instances, exacerbated a preexisting problem that led to harm or death. True negligence by any party resulting in harm occurred in less than 1% of these reported incidents, and the use of the term malpractice to sensationalize this story was clearly irresponsible. It is frustrating for all of us to spend a lifetime and career where statements are based on known data and then have to respond to clearly inaccurate statements in the press that are assumed by the public and even politicians to be true. Now what is the real problem and what can we do as physicians to help solve it? How can we continue to improve and provide the best possible care to our patients? We are not perfect and to err is indeed human. There, that's off my chest!

A very helpful and constructive premise I heard at the Baltimore meeting was to approach the non-negligent vast majority of these harmful incidents as medical misadventures rather than simple error. This seems to be the first step toward bringing solution rather than blame and accountability into the picture. Also from that meeting came the following facts.

- The vast majority of medical misadventures result from system failures such as transcription error, illegibility, loss or misfiling of reports and miscommunication.

"We are not perfect and to err is indeed human. . There, that's off my chest!"

- A major majority of misadventures involve the use and administration of medications in the treatment and prevention of illness, usually when treating the seriously ill.
- Negligence resulting in harm is found only in a very small minority of cases of medical misadventure. Though these are the banner cases of notoriety, they are relatively small in number.
- A measurably significant percentage of misadventures characterized as mistake or error are in fact unavoidable in a complex and technically sophisticated system of medicine with its attendant risks but resultant rewards.

Physicians and physician organizations can certainly take action themselves to reduce medical

(Continued)

misadventure. A number of proposed solutions have already become evident in early discussions among the "experts". Simplest, easiest and least expensive are measures to improve communication and collaboration between all members of the health care team. Physicians can no longer behave as the omnipotent king not to be challenged. All of us can honestly recall instances where open, equal communication with another caregiver would have prevented confusion and error. This is true physician to physician, physician to nurse or other team member, between team members, and conversely in all these situations, as well. Many (an estimated 50%) of medical errors could be eliminated by open communication within a system of checks and balances.

Increased automation and use of modern technology may offer the most effective long term solutions to reducing error rates. Medical systems are woefully behind other public enterprise in this arena. Single resource electronic medical records and data bases (not handwritten), data entry prescription systems (not handwritten), and electronically monitored and cross checked order entry systems have already been shown to drastically reduce systems and personal errors. Many other electronic advances are on the horizon to simplify our work and help us make more accurate and efficient. We must be open to these solutions and implement them as possible. Of course technology and electronic solutions are expensive initially but data is already showing that savings from efficiency and decreased error rapidly recovered startup costs. This data confirms the impression that medical error is expensive as well as harmful.

I hold little faith a new Federal agency established to categorize, demonize and punish medical error will be at all effective in addressing this problem. Certainly any national effort must, in our current legal environment, isolate and make confidential any error reporting system or its data will be incomplete and inaccurate for reasons of basic human self preservation.

A multidisciplinary task force is meeting to address these issues in Colorado, and your president-elect, Richard Allen, M.D., is involved. Certainly we as individual physicians, organizations, affiliations and societies must work with each other and all other health care professionals to reduce medical error.



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CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the Annual Meeting of the House of Delegates in Aspen, September 22, 2000. We request nominations for the following:

- American Medical Association (AMA) Delegates
- AMA Alternate Delegate
- Colorado Medical Society Speaker of the House of Delegates
- Vice-Speaker of the House of Delegates
- CMS President-elect

Dr. Richert Quinn is running for re-election as AMA Delegate.

Dr. Steve Thorson, is running for re-election as AMA Alternate Delegate.

Dr. Robert McCartney does not plan to run for re-election as AMA Alternate Delegate.

Dr. Jack Berry is a candidate for election as AMA Alternate Delegate.

Dr. Louise McDonald is a candidate for President-elect of CMS.

Dr. Sherri Laubach is running for election as Speaker of the CMS House of Delegates.

There is currently no nomination for the post of vice-speaker.

If you are interested in being a candidate for any of the above offices, please submit your name and a current resume' to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550. If you have any questions, contact either Sandra Maloney or Debra Jones at 720-859-1001 or 1-800-654-5653.

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. . . a compilation of medically-related news briefs of immediate interest to the physician community occurring after COLORADO MEDICINE has gone to press. **AT PRESS TIME . . .**

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Anatomy of Domestic Relations Cases

By Karen B. Best

Although the cry goes out to "Simplify!" in practice most of us continue to complicate. Divorce law is no exception. Judges complain that there are too many experts in divorce cases. Parents complain that courts and people they don't even know are taking over their sacred parenting domain. Clients complain that it costs a small fortune just to get a divorce. How can this be happening when we live in a no-fault divorce state? It's supposed to be simple. Although no-fault divorce laws have eliminated blame from the issues to be litigated in a dissolution of marriage, there are still so many other things to fight about.

This article discusses generally how divorce and family law cases are becoming more complex, more expert-intensive, and therefore more costly. It also discusses the role of health care professionals in these cases. This article is not and cannot be all-inclusive, simply because it's all too complex.

Divorce Terminology: First a word about the terminology of divorce, which also has become more wordy, if not more complex conceptually. People no longer get divorced; there is a dissolution of marriage. One pays maintenance, not alimony. Visitation has become parenting time. Custody is now referred to as parental decision-making responsibility. A custody evaluation is a parental responsibilities and parenting time evaluation. In addition to having a separation agreement, a divorcing couple with children must also have a parenting plan the softer, more descriptive words avoid the concept of children as chattel. If a parent lost custody of the children, he or she lost the children. They belonged to someone else. The non-custodial parent could visit them; but make no mistake, he had lost the kids. Or at least that's how it felt to many parents. Now we speak of parental responsibilities and parenting time. There's no such thing as custody. A parent can't lose the children, even if he or she wants to.

The term "parental responsibilities" is more descriptive of what has always been the legal meaning of "custody." "Custody" is actually the right to make major decisions affecting a child's education, health care and religious training. In the parenting plan, the allocation of these parental decision-making responsibilities is spelled out, along with methods of dispute resolution.

The new terminology is consistent with the Legislature's declaration concerning the best interests of children, which almost seems out of place in a set of statutes. "The general assembly finds and declares that it is in the best interest of all parties to encourage frequent and continuing contact between each parent and the minor children of the marriage after the parents have separated or dissolved their marriage. In order to effectuate this goal, the general assembly urges parents to share the rights and responsibilities of child-rearing and to encourage the love, affection, and contact between the children and the parents."

Accomplishing what seems to be a modest goal - maintaining contact between parents and children - can in some cases require several experts and substantially raise the cost of finalizing the dissolution of marriage.

(continued on next page)

CMS Med Fax

Which all goes back to the fact that even though Colorado is a no-fault divorce state, there are still so many things to fight about; for example:

The Children: Historically, the question of which parent would have custody of the children after the divorce was fairly simple to answer. Usually Mom stayed home with the kids and Dad worked. In most cases, the children were presumed to be more attached to the stay-at-home Mom than to the bread-winning Dad. Consequently, most Moms were awarded custody of the children, based almost entirely on the history of care. Dad could see the kids every other weekend, every Wednesday evening for dinner, and two weeks every summer. It was pretty simple and predictable. Kiss those days good-by.

With the change in roles for both men and women, old axioms have been displaced. Urged on by parents, attorneys, and child development and mental health professionals, the legislature and courts now recognize that, if the goal is to do what's best for the children in a situation which is by its very nature (in many cases) not good for the children, they must look farther deeper into the relationships between each of the parents and the children. Today there are many cases of co-parenting with equal attachment. A parent who worked more during the marriage may work less after the divorce, whether by choice or necessity. In some cases, as a result of inadequate or harmful parenting, the child actually is more attached to, and should be with, the parent who spent less time with the child.

Now, instead of looking to the past to predict the future, we have a battery of professionals who are retained specifically to figure out how and by whom the children should be raised. Does this make you a little uneasy?

When "custody"[1] of the children is at issue, parents can ask the court to appoint a "child's legal representative" or a "special advocate" or a "custody evaluator," or all three, to assist the court in making its determinations about the children. The court can make appointments on its own initiative as well.

A child's legal representative is a lawyer whose role is to protect the best interests of the child with respect to the child's custody, the allocation of parental responsibilities, support for the child, the child's property, parenting time, and any other issue related to the child.[2] The child's legal representative cannot testify as a witness in court.

By contrast, a special advocate, also court-appointed, may be an attorney or a mental health professional.[3] This person investigates, reports and makes independent and informed recommendations to the court on any issues that affect the best interests of the child. The report includes the expressed wishes of the child. Although the special advocate is required to consider the wishes of the child and to report those wishes to the court, the special advocate is not required to adopt those wishes in making his or her recommendations to the court, unless they serve the child's best interests. The special advocate may testify in court.

The legislature has declared that "children have certain rights in the determination of matters relating to parental responsibilities, including the right to have such determinations based upon the best interests of the child."[4] However, Colorado has not adopted any rule stating that children over a certain age may choose which parent to live with. Only in recent years has the legislature included the child's wishes as a factor to be considered when determining parental responsibilities or parenting time.[5]

The custody evaluator[6], a qualified and licenced mental health professional, performs a much more in-depth review of the family than either the child's legal representative or the special advocate, at proportionately greater cost. The evaluation consists of interviews of the parents and the children to obtain a history, psychological testing, observations of each parent and the child together, interviews of others involved with each of the parents, and an assessment of the extent to which each parent is capable of promoting e relationship between the child and the other parent. The evaluator can refer the child to other professionals for diagnosis, and may consult with and obtain information from medical, mental health, educational and other expert persons who have served the child in the past. The evaluator may do so without the consent of any child under 15 years, and with the consent of a child over 15, unless that child lacks mental capacity to consent. The goal of the evaluation is to predict which arrangement will be best for the child. The evaluator's recommendations carry great weight with judges, unless the judge finds the evaluator has done a poor job or is otherwise incredible. If one party is not satisfied with the result of the first evaluation, a second evaluation may be requested and may be ordered.

Much has been written about the efficacy of custody evaluations7: Do psychological tests accurately or reliably predict parenting ability or outcomes for the children? Does behavior in the artificial setting of an evaluation predict how the parent and child will interact in everyday circumstances, like at bedtime, in the grocery store or at the dinner table? Can the evaluator expect to obtain objective data from others involved with one or the other of the parents? Would any parent in his or her right mind ever admit that he or she has no intention of letting the

(continued on next page)

child develop a close and loving relationship with the other parent? Aren't the evaluators just guessing when they make their recommendations?

Whether the professionals are guessing or not, the reality is that judges. parents, and attorneys rely on these experts. What they say often determines what happens to the children

2. Alimony and Maintenance: The traditional family still exists. Wife stays home to take care of the children and Husband earns the money. Historically, in long-term marriages the wife was awarded alimony for life and was not expected to get a job, much less develop a career. The wife was not expected by the courts to support herself in a substantial way.

Now, even in long term marriages, the trend is toward "rehabilitation" of the non-working spouse and shorter time periods for the payment of maintenance. Even if a person has not worked for many years, or never, there is an expectation that, in the absence of a physical or mental disability, the person will get a job and support herself. Maintenance is most often paid while the person rehabilitates herself and until she can bring her earnings up to a subsistence level. It's rarely up to the pre-dissolution level. Unless maintenance is "contractual" and "non-modifiable" it can be increased or decreased, extended or terminated by a showing of changed circumstances which render the existing maintenance order unconscionable.

The maintenance issue calls into play several experts, including the vocational evaluator as well as physicians and mental health professionals. The vocational evaluator looks into a party's educational background, work history, and employment skills, performs various tests of aptitude and dexterity, and makes findings about the person's employability and the likely range of salary that person is capable of earning over time.

In some cases a non-working spouse claims that he or she is unable to support himself or herself due to a physical or mental illness. In other cases one spouse may claim that the other spouse is not a fit or proper parent to have residential care of the child, or to make decisions for the child, due to a physical or mental illness. In these cases, it is appropriate to request an independent medical or psychological evaluation. All of the records for that spouse are discoverable. The concept is the same as in a personal injury case: when a party's physical or mental condition is at issue, an exam and disclosure of pertinent medical and psychological information are appropriate.

3. Finances: Lawyers haven't found a way to involve physicians or mental health professions in the valuation and division of property. However, valuation of property can require the assistance of CPAs, real property appraisers, and personal property appraisers. CPAs routinely value pension and retirement plans and business interests. The valuation of nontransferable unvested stock options poses a challenge that is being addressed through calculations requiring computer programs to perform, not to mention a little hocus-pocus. It is not unusual for each party to retain his or her own experts.

Colorado still uses equitable principles to divide property. This means that property acquired by parties during the marriage will be divided in a fashion that is "fair", but not necessarily equal.

Of course, there are still many cases that do not require multiple or duplicative experts (even in the presence of children), substantial assets and debts, and complex financial pictures. Those cases ordinarily involve one common element: the parties put their emotions aside to get the job done. This is not easy. These people never require the appointment of mental health professionals to decide which baseball team the child will play on, or a court order determining who will clean the mildew off the tub. They are generally motivated to resolve their differences in the most amicable and cost effective way possible, and to move on. Simplify!

REFERENCES:

1. The Uniform Dissolution of Marriage Act, Colorado Revised Statutes (C.R.S.), § 14-10-101 , *et seq.*, no longer refers to "custody" of the minor children. This term has been replaced by the term "parental decision-making responsibility," which will be discussed further.
2. Section 14-10-116(2)(a), C.R.S.
3. Section 14-10-116(2)(b), C.R.S.
4. Section 14-10-113.4, C.R.S.
5. Section 14-10124(1.5)(a)(II) and (b) (In determining the best interests of the child for purposes of parenting time [and parental responsibilities], the court shall consider all relevant factors, including: ... The wishes of the child if he or she is sufficiently mature to express reasoned and independent preferences as to the parenting time schedule....)
6. The custody evaluator is more appropriately referred to as a parental responsibilities and parenting time evaluator, to reflect the 1988 amendments to the Uniform Dissolution of Marriage Act.
7. See, for example, "Critical Analysis of Parental Responsibility Evaluations," Griffith and Schweissing, 29 Colorado Lawyer No. 4, p. 63.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

5th International Conference on Pediatric Trauma
June 17-20, 2000
Vail-Beaver Creek, Colorado
Contact: (719) 365-5888 or *www.pedtraumaconf.org*

9th Annual Rural Health Conference
June 21-23, 2000
Gunnison, Colorado
Contact: (303) 832-7493 or (800) 851-6782

Teens and Trauma
June 29-30 and July 1, 2000
Grouse Mountain Lodge
Whitefish, Montana
Contact: (406) 752-1775

Internal Medicine Program
July 9-14, 2000
YMCA of the Rockies/Estes Park Center
Estes Park, Colorado
Contact: (303) 372-9065

Colorado Academy of Family Physicians Annual Scientific Meeting
July 20-22, 2000
Sheraton Steamboat Resort
Steamboat Springs, Colorado
Contact: (303) 696-6655 or *E-Mail: cafp@iex.net*

"Women Physicians: Finding a Balance"
July 20-23, 2000
Iron Horse Resort at Winter Park
Winter Park, Colorado
Contact: (303) 470-3441

Renal Disease and Electrolyte Disorders
July 24-28, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

26th Annual Psychiatry Conference
August 2-4, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

Neurology Update
August 4-6, 2000
Aspen, Colorado
Contact: (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

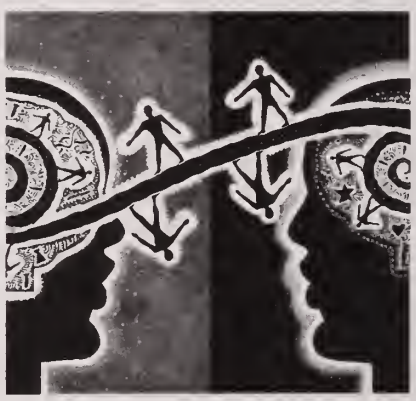
How To Practice Evidence-Based Health Care
August 6-10, 2000
Sonnenalp Resort
Vail, Colorado
Contact: sharlyn.walling@uchsc.edu or call (303) 315-7606

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Update on Infectious Diseases in Primary Care
September 16, 2000
The Antler Adam's Mark
Colorado Springs, Colorado
Contact: (303) 372-9065

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

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Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

I was browsing the other day and ran across a report from the American Health Information Management Association (AHIMA). This organization's journal is running a three-part special report on megatrends in the healthcare industry.

In the first article, one of the trends discussed is that of changing consumer perceptions and expectations of the healthcare industry. This immediately got my attention because I, like most everyone else in this business, continue to look for some overall public attitude, which has not been very well defined up to now. The report quotes a recent Arthur Andersen and Healthcare Forum study on healthcare and leadership, *"Leadership for a Healthy 21st Century."* The article highlights the consumer viewpoint, and AHIMA puts forth selected points from the study that emphasize what consumers want in health:

- Choice - Choice is no longer solely and issue about choice of physician. Consumers are expanding the definition of choice to mean choice of treatment.
- Optimizing prevention - Consumers are able to articulate a long list of preventive actions and also understand that prevention saves the system money. Accordingly, they feel all prevention techniques, including vitamins and herbal therapies, should be covered by insurance.
- Access for all - The issue of insurance coverage for all Americans, regardless of economic status, remains a major concern for consumers.
- Children's health - For those with children, the most important healthcare concerns are those relating to their children's health.
- Alternative approaches - Consumers report awareness of, interest in, and experimentation with a wide variety of "alternatives" such as herbal medicine, aromatherapy, massage, acupuncture and chiropractic care.
- A "customer in charge" attitude - Empowered through information, customers are more willing to challenge "doctor's orders."
- Reduced hassle and more convenience in healthcare delivery - Consumers report significant and often infuriating delays and demonstrations of disrespect in their interactions with the delivery system.
- Perception of not being given enough "time" as both a real problem and a symbolic sign of disrespect - Consumers, especially women, are extremely sensitive to perceived cutbacks in the amount of time furnished by physicians and other healthcare providers.

I find these trends very interesting and something we should be watching carefully.

Why, you ask, am I out looking at other organizations' materials and research? Because it is my continual effort to see what anyone thinks which might help the physician to a better patient relationship.

The primary job of the members of this organization (AHIMA) is to analyze health information to help direct the efforts of hospitals, physicians, long-term and managed care organizations. Frankly, I don't care where the information comes from or whether it is based on strict scientific analysis; the information put before me catches my interest because it speaks to a list of things that all physicians should be aware of and working toward better patient understanding. This article succeeded in that light.

AHIMA I thank you!

People ". . . are more willing to challenge 'doctor's orders'."

You can look at the complete article by going to AHIMA's Web site at www.ahima.org, then follow the links to "Information Center," "Journal of AHIMA" and then to "Feature Articles."



John L. Lightburn, MD
Historian
Colorado Medical Society

Into the sixth decade of the 20th Century

As we continue our historical travels toward the end of the century, it becomes apparent that the CMS presidents were an extraordinarily diverse group of leaders, each a strong individualist basically reflecting the character of the medical profession of their day. Since we are approaching the present generation, sometimes we will be paying tribute to past presidents who are still with us. Some of you readers will have known these men and may find my comments inaccurate or misleading. I welcome any comments, corrections or additions.



Ervin A. Hinds, MD

Our 80th CMS president, 1950-51, was Ervin A. Hinds. After an outstanding academic and athletic record in his Brighton High School, he went into the US army, spending 18 months in France in the tough Artillery during World War I. Returning to Colorado in 1919, he spent the next four years in the Colorado College of Agricultural and Mechanical Arts (now Colorado State University) where he won both good grades and 10 athletic letters including Rocky Mountain Conference heavy weight boxing champion. Erv wanted to be a surgeon, but even in these prosperous times money was a problem. So with his outstanding athletic ability he coached seven years, three years in high school and four years as coach and Athletic Director at the Colorado School of Mines in Golden. Even after he received his MD, admiring friends and colleagues referred to him affectionately as "Coach". He was a big handsome man; he looked like a coach. Coaching was fun, but his dream of being a surgeon could not be denied. He lived frugally and saved enough money to support him through four years of medical school, internship and residency; he was 37 when he began the private practice of surgery in Denver. World War II took him to England where he was Chief of Surgery of the 154th General Hospital.

In his presidential address, he recalled that while in the armed service, he had taken a solemn oath "....to defend the Constitution of the United States against all enemies foreign and domestic." He still followed that oath and believed that the domestic enemies were the socialists in Washington who wanted to deprive doctors and their patients the freedoms Americans valued so dearly. He believed the foreign enemies were the communists. Just three months before Dr. Hinds had delivered this address, North Korea had launched a surprise invasion of South Korea. President Truman, determined to contain the very serious threat of world wide communist expansion, had established the "Truman Doctrine". He therefore sent American troop to Korea. Erv Hinds had little respect for Harry Truman because of his support of a National Health Plan, but he strongly supported Truman's decision to draw the line in Korea. He urged the medical profession to support the military. He noted that during the recent World War II, the ASTP and V12 programs had provided a free medical education to thousands of young men. "Yet in the present emergency repeated appeals from our armed forces to 3,000 of these young men brought only seventeen volunteers. The medical profession decried the failure of these young men to meet their moral and patriotic obligations." He called for a new system to activate these young doctors. He ended his powerfully patriotic address with an eloquent oath that he would defend the Constitution, bear true faith and allegiance to American Liberty and to "faithfully discharge the duties of this office; so help me God". Dr. Hinds was truly unique in his sincere devotion to his country and his profession.

Harry C. Bryan, Colorado Springs surgeon, was our 81st CMS President. He was born in 1893, a Texan and received his degree in pharmacy from the University of Texas in 1915. Two years later, his bride developed pulmonary tuberculosis which prompted them to move to Colorado Springs where he became the pharmacist at the Busy Corner Drug Store. He found this unrewarding and soon was working

for *Eli Lilly & Co.* as their representative. He was dedicated and conscientious and soon knew almost every physician in his region. His admiration and affection for physicians grew, and he became determined to become a physician. He saved efficiently and invested prudently and by 1933 at the age of 40 he had completed his premedical courses, medical school at CU, internship and surgical residency at Colorado General Hospital and had returned to Colorado Springs to begin a very successful Surgical practice



Harry C. Bryan, MD

He was a man of strong religious faith and dedicated to the profession of medicine. He also had confidence in the American system of government; he had a burning zeal to improve both the profession and the government at every level. In his presidential address, he called for a massive movement for better medical, health and welfare laws. Physicians must provide the leadership their communities need.

He never charged high fees nor tried to force payment from delinquent patients (and openly disapproved of those who did). Nevertheless, he was a financial success largely due to his wise investing. He was an expert dry fly fisherman, and he never used bait or lures in order to give the fish a fair chance. He and his wife enjoyed foreign travel, and his last trip ended in Suez on March 18, 1967 when he died of a massive cerebral hemorrhage.

The CMS House of Delegates chose Denver internist, William A. Liggett as our 82nd President. His was a challenging term of office, a term that required restraint and patience. Long before becoming a doctor, he portioned his own medical education by becoming a teacher in order to help finance his brother Bob's, medical education. Once in practice, Bob reciprocated for Bill's medical education. Bill was 37 when he received his MD from the University of Colorado in 1938. They practiced together for a few months in 1942, then both went into the armed services. Bill's service included nine months in the tough China-Burma-India theater. The many interruptions that postponed the realization of his dream of practicing medicine until he was 44. It was a lesson that taught patience and forbearance.



William A. Liggett, MD

Although active in the affairs of CMS, he felt unprepared for the office of presidency and had studied the requirements of his new job. A few days before installation, his wife had presented him with their fourth child, their third daughter. While still in the glow of this event, he was astonished and taken aback just an hour after his installation when the new Chairman of the Board of Trustees, McKinnie L, Phelps, tapped him on the chest and said, "Now, remember - you're just the President; I'm Chairman of the Board and I call the shots." A two year struggle began that day, though since 1949, chairmen had occasionally used the powers given to the President by the bylaws. He rallied support from the component societies and the House of Delegates. Late as a past-president, he urge the CMS to purchase its own building, and he inspired several other past-presidents to join him in furnishing and equipping the special Presidential office.

In his presidential address, he announced with pride that in AMA circles, CMS was ranked among the top three state medical societies. He paid tribute to Dr. George Unfug, who as president sent monthly letters to the members in the Armed Services during world War II. Of the hundreds of medical officers he had known while in the service, none had received a letter from their state society. Colorado led the nation in the development of prepaid medical service plans. As his predecessors had done before him, he warned of the continuing danger of federalization of the practice of medicine, warning his listeners that the coming national election would have important consequences to our profession.

For Claude D. Bonham, MD, the 83rd CMS presidency was not a happy place to be, and involved considerable sacrifice and anguish. His administration inherited a discordant Board of Trustees which continued its already year long bickering (they had three year terms). Certain members of the Board were still trying to strip the presidency of any power. Then, only two months after he was installed, he lost his partnership in the Boulder Medical Center because some of his partners thought he devoted too much time to the Medical Society. Truth be told, he had spent an enormous amount of time in the Colorado and the Boulder County Medical Societies. So he moved his ob/gyn practice to Denver; practice was slow at first, so he devoted almost full time to the presidency. His hands were tied for the year by certain difficult members the Board. But his testimony to a special investigating committee and a

(Continued)



Claude D. Bonham, MD

detailed report to the House of Delegates precipitated a reorganization which clarified lines of authority.

We had initiated his presidency with a presidential address which he opened by quoting the inscription above the doors of the Norlin Library on CU's Boulder campus: "He who knows only his own generation remains always a child." We must learn not only by our own experience but also by the experience of others. Past experience has taught us that we as a profession must unite and become active politically. He devoted most of his address to a discussion of the Veterans Administration hospital system which had grown to 199 hospitals and domiciliary units with 152,600 beds. The system cared for 20,000,000 which, he said, represented 40% of the total male population. (His arithmetic is faulty; 25% is closer to the truth). The VA provides care to these men with no requirement that the medical problem be service connected. With the continuing increase in the veteran population, "By even the most elementary calculations . . . it will amount to the almost total socialization of medical care." So the threat of socialized medicine again raises its ugly head.

Since 1932, CMS presidents had spoken out with eloquent words in vigorous opposition to the seeming endless efforts by Washington "bureaucrats" to take over the practice of medicine. The unintended consequence of their sincere efforts may be the current bureaucracy known as managed care. They fought a good fight.

NOTE: If you have particular interests in Colorado Medical Society history and a possible subject you'd like to see researched and published, please write down as many details as you have of the person or persons. Send this information with your request to ***Colorado Medicine***, Attention: Editor, P. O. Box 17550, Denver, CO 80217-0550. We'll search the CMS Archives and let you know what we find. If we have sufficient factual material we'll be happy to publish it in an article

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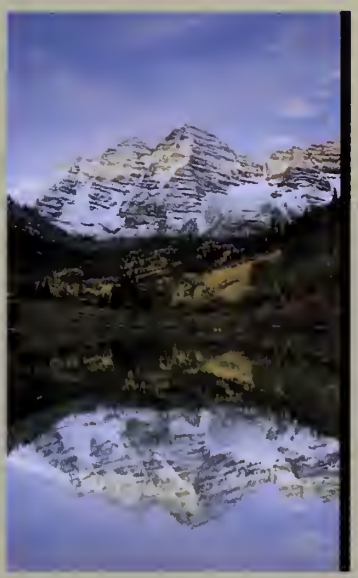


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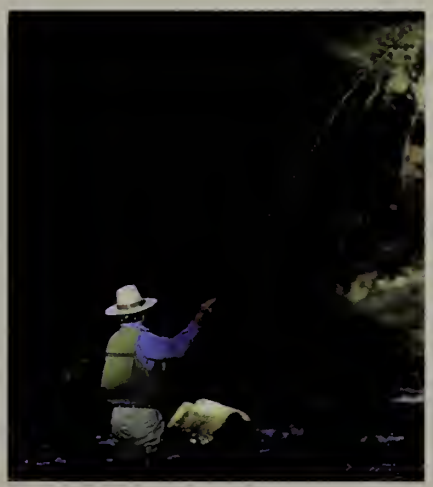
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*** For 24 hr. immediate information, the CMS link to RMFA includes *WebCarbooks*, the highest rated vehicle price and option guide on the internet.**

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Annual Meeting Registration

2000 Annual Meeting of the Colorado Medical Society
St. Regis Hotel • Aspen • September 22-24, 2000

Name (please print) _____

Component Society _____

Name of Spouse/Guest(s) _____ **CMS Alliance Member** ❑**Yes** ❑**No**

*If you are not a member of CMS, please provide the following information and **$125** for registration fees:*

Company/Organization _____ **Title** _____

Registration deadline is September 11, 2000. Registrations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. *(Note:* If you have not pre-registered for Saturday's dinner/dance, you must do so before noon on Friday, Sept. 22 at the Registration Desk.)

Complimentary Events for CMS Member & Spouse/Guest
Except for the COMPAC/Alliance Luncheon, you and one guest are entitled to attend all events at no charge. To confirm your reservation, use the boxes below for yourself and one guest and the shaded area for additional guests.

Thursday, September 21	member	spouse/guest
6:00 pm Welcome Reception	❑	❑

Friday, September 22	spouse/guest
8:00 am Alliance Breakfast	❑

Saturday, September 23 *(Complimentary for member & one guest **only**)*	member	spouse/guest	CHARGES FOR ADDITIONAL GUESTS
7:00 am Breakfast Buffett	❑	❑	# _____ @ $25/each _____
8:00 am Education Program	❑	❑	
12:45 pm AMA Forum Luncheon	❑	❑	
7:00 pm President's Dinner Dance			
Meat dinner	❑	❑	# _____ @ $95/each _____
Vegetarian Dinner	❑	❑	# _____ @ $95/each _____
Vegan Dinner	❑	❑	# _____ @ $95/each _____

Other Events

Friday, September 22 * CHARGE PER PERSON FOR **ALL** MEMBERS AND GUESTS

12:30 pm COMPAC/Alliance Luncheon #_____@ $35/each*_____ COMPAC Member
#_____@ $45/each*_____ Non-COMPAC Member

Please make check payable to: **Colorado Medical Society** and mail this form.

TOTAL amount enclosed for non-members, additional guests and COMPAC Luncheon. **$** _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 720-859-1001 or 1-800-654-5653); or fax it to us (at 720-858-7509).

Hotel Reservation deadline is 8/13/00.

Hotel Registration

The St. Regis Aspen Room Reservation Request From

Colorado Medical Society Annual Meeting - September 22-24, 2000

It took peaks as high as the Rockies to match the height of service The St. Regis Aspen aspires to. It took the premier resort of Aspen to set the standard for a vacation experience. It took the traditional elegance of The St, Regis Aspen's mountainside accommodations to bring all this together under one roof of luxurious appointments.

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The St. Regis
ASPEN

Please print or type the following and mail or fax form with deposit payment to The St. Regis Aspen:
315 East Dean Street, Aspen, CO 81611
970-920-3300 Phone
970-920-7353 Fax

Name_____

Address_____City_____State_____ Zip Code_____

Phone number_____ Number of guests_____

Fax number_____ E-mail address_____

Arrival date_____ at_____ AM/PM (Check in time is after 3:00 PM)

Departure date_____ at_____ AM/PM (Check out time is 12 noon)

$175 single/double occupancy

Rates are per room per night and do not include the room tax, currently 8.2%.

❑ king bed ❑ 2 double beds ❑ smoking ❑ non-smoking

Method of payment

❑ Check enclosed ❑ American Express ❑ MasterCard ❑ Visa ❑ Diner's Club ❑ Carte Blanche

Account #_____ Exp. date_____

Signature of card holder_____

Deposit and cancellation policy: A deposit equal to 100% of total nights booked is required in order to confirm your reservation. This deposit is due 30 days prior to your arrival. Should The St. Regis Aspen not receive the deposit, the reservation will be cancelled. Your deposit is refundable if reservations are cancelled more than 30 days prior to arrival. All deposit money is non-refundable if a cancellation is made within 30 days of the arrival date, or if you check out earlier than your scheduled departure date.

Reservation cut-off: Rooms will be held for the attendees of the Colorado Medical Society Annual Meeting at the special rate for the nights of September 20-24, 2000, until August 13. Reservations received after August 13, 2000, or for days other than 20-24, 2000, will be accepted on a space available and charged at the prevailing hotel rates.

Use of the Fitness Center will be billed at $6 per visit.

Overnight valet parking will be billed at $17 per night, reduced from $19/night for CMS guests.

Special requests:

Please check that you have completed all pertinent information. Reservations should be made **before** August 13, 2000, to assure accommodation availability.



TEE UP!

Entry Form

CMS Annual Meeting Golf Tournament
Aspen Golf Course
Thursday, September 21, 2000



Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____

Home Phone _____ Fax Number _____

E-mail Address _____

While in Aspen I will be staying at _____

My golf handicap is _____ or My average score is _____

I prefer to be teamed with _____

If you would like to play, please return this entry form as soon as possible because space is limited.



Tournament tee times are reserved starting at 8:08 am. Foursomes to choose their own type of play (scramble, Individual, etc.). Prizes to be awarded for individual contests (long drives, closest to the pin, etc.) Foursomes will be arranged; please specify if you have a preference of partners. To ensure tournament registration, please send entry form and advance payment of $130 by September 1, 2000 to:

Barbara Campbell, 2251 Ash Street, Denver, CO 80207. For more information please call Barbara at 303-388-5307 or email to BarbLRA@aol.com.

Annual Meeting Schedule

The St. Regis Hotel-Aspen • September 22-24, 2000

Thursday, September 21st

8:00 am	CMS Office open
8:00 am	18-hole Golf Tournament - Aspen Golf Course
1:00 pm-2:00 pm	Finance Committee
2:00 pm-5:00 pm	Board of Directors
4:30 pm-7:00 pm	Registration open
6:00 pm-7:30 pm	Welcome Reception Dinner on your own

Friday, September 22nd

7:00 am	CMS Office opens
7:00 am-4:00 pm	Registration
7:00 am-7:45 am	Reference Committee Breakfast
7:00 am-7:45 am	New Delegate Orientation
7:00 am-7:45 am	Rural Physicians Forum
7:00 am-8:00 am	COMPAC Board
8:00 am-12:00 N	Exhibits open
7:45 am-8:00 am	Credentials Committee
8:00 am-8:30 am	Opening Session - House of Delegates
8:00 am-9:30 am	CMS Alliance Breakfast
8:30 am-12:15 pm	General Membership Meeting
9:30 am-12:00 N	CMS Alliance Membership Meeting
12:20 pm-1:45 pm	COMPAC/CMS Alliance Luncheon
2:00 pm-3:00 pm	Copic Risk Management
2:15 pm-4:30 pm	Reference Committee
3:15 pm-4:15 pm	Copic Risk Management
3:15 pm-5:15 pm	Reference Committee
6:30 pm-7:30 pm	Colorado Chapter, American College of Physicians/American Society of Internal Medicine (ACP/ASIM)
7:00 pm-9:30 pm	Gone But Not Forgotten Dinner (by invitation only)

Saturday, September 23rd

7:00 am	CMS Office opens
7:00 am-11:00 am	Registration
7:00 am-7:30 am	Breakfast
7:30 am-12:45 pm	Education Program
9:00 am-11:30 am	CMS Alliance Program
10:00 am-10:30 am	Break
12:50 pm-1:55 pm	AMA Forum Lunch
2:00 pm-5:00 pm	Copic Financial Seminar
5:30 pm-6:15 pm	Meet the Candidates Reception
6:15 pm-7:00 pm	Inaugural
7:00 pm-10:30 pm	Presidents' Dinner/Dance
8:30 pm-10:00 pm	Copic Dessert Reception

Sunday, September 24th

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 am-9:30 am	Registration
7:00 am-8:30 am	Component Caucuses (Arapahoe, Aurora-Adams, Boulder, Clear Creek Valley, Denver, El Paso, Larimer/Weld, Pueblo/Western Slope)
8:15 am-8:30 am	Credentials Committee
8:30 am-12:00 N	Closing Session House of Delegates
12:00 N or immediately following HOD	Reorganizational Board

Dine & Dance
to the music of
Colorado Power Company



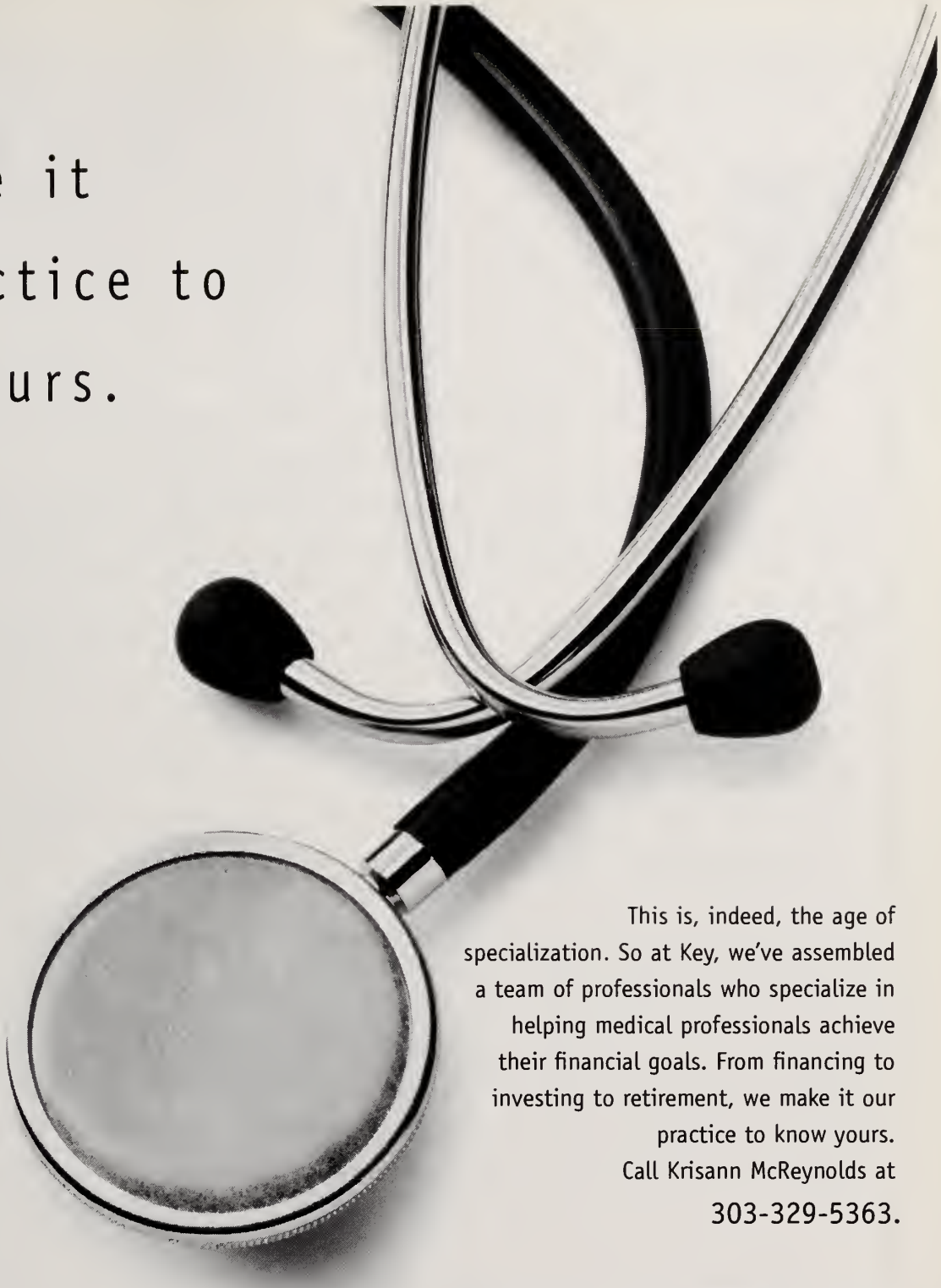
at the
President's Dinner-Dance

Saturday Night, September 23rd. Reception form 5:30 - 6:15, inargural 6:15 - 7:00. Dinner at 7:00.

The ***Colorado Power Company*** *is a 9-piece band that plays a variety of music from the Swing Era and Neo/Swing to Latin, Classic Rock, and some Country.*

The band includes the piano, upright and electric bass, drums, guitar, saxophone/flute/clarinet, 2 trumpets, trombone, and female vocalist. Five members of the band are also vocalists. ***Colorado Power Company*** *is from Carbondale, Colorado, and performs at many Aspen Valley functions. Directed by Bill Parish, the Colorado Power Company is a well known and popular music group.*

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We invite your nomination for the

Colorado Medical Society

Physician Award for Community Service 2000

(formerly the Wyeth-Ayerst Physician Award for Community Service)

The Colorado Medical Society wishes to continue this important physician service recognition, and will do so based on the same qualifications required in past years.

Those qualifications are as follows.

The physician must:

1. Be a member in good standing of the Colorado Medical Society, licensed to practice medicine in Colorado;

2. Be recognized for outstanding community service, separate and apart form his/her medical service or activities.

We wish to honor the physician judged by his/her colleagues to have contributed most significantly to civic activities and the community good. All nominations must be accompanied by documentation of the physician's community services; i.e., testimonials from community leaders, honors and awards received by the nominee for outstanding community projects, testimonials from peers, friends and associates.

Address all nominations to:
Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550

Nominations must be received by Midnight, July 31, 2000, to be considered. The award will be presented at the CMS Annual Meeting in September, 2000, at the St. Regis Hotel in Aspen, CO.

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



"3Rs" Pilot Program Launches July 1: PHYSICIAN PARTNERS NEEDED

Under the leadership of its founding Chairman, K. Mason Howard, M.D., Copic Insurance has developed a pilot program known as The "3Rs" to enhance physicians' ability to meet patient expectations and potentially forestall litigation and associated costs following treatment-related injury. The "3Rs" refer to the program's overall goal of giving physicians the appropriate communication tools, skills, and support to recognize, respond to, and resolve patient injury in a way that preserves the physician/patient relationship.

The "3Rs" Pilot Program is scheduled to begin on July 1, 2000. Copic is seeking a total of 500 physicians (300 surgeons and 200 non-surgeons) to participate in the "3Rs" Pilot Program. The pilot will run for two to three years, at which time an actuarial study will determine its overall value and impact. According to Dr. Howard, approximately 200 physicians in the Denver metro, Grand Junction, and Fort Collins areas have already signed on.

The program provides a framework for physicians and Copic Risk Managers to:

- Recognize iatrogenic injury and respond more immediately (within 72 hours);
- Communicate with the patient in an empathetic manner;
- Ensure that the patient receives prompt evaluation and consultation;
- Arrange for additional care or services that the patient might need as a result of the injury (a special no-cost policy enhancement makes funds available to reimburse patients for injury-induced periods of disability and associated out-of-pocket costs not reimbursable under the patient's medical insurance); and
- Resolve the episode in the most satisfactory manner for all parties.

Under the "3Rs" Pilot Program, a participating physician will call a specially-trained Risk Manager when a patient sustains a treatment-related injury (just as he or she would for any other incident). Next, the physician and the Risk Manager meet to review the event and determine how to proceed to resolve the problem. Then the physician, the patient, and the Risk Manager meet to discuss the event and come to resolution.

There are at least five good reasons why you should consider participating:

1. There's no risk to your professional reputation, since payments to patients under the "3Rs" Pilot Program are exempt from reporting to either the National Practitioner Data Bank or the Board of Medical Examiners.
2. There's no risk of causing your premium to increase, since funds used to reimburse patients under this pilot program are drawn from surplus, not from physician premium payments.
3. There's no risk to your insurability, since information about incidents and payments under the "3Rs" Pilot Program would have underwriting significance only if a patient were subsequently to take legal action and prevail.
4. You will earn one ERS point for each year of participation, simply for agreeing to call in treatment-related injury incidents as you would any others.
5. Because the program's focus is on preserving the physician/patient relationship, there's a real possibility that participation will result in lower liability losses in the long run.

Physicians who wish to participate in the "3Rs" Pilot Program are invited to call K. Mason Howard, M.D., at (720) 858-6159 or (800) 421-1834, ext. 6159.

CMS Online

Latest news from Colorado's largest physician organization:

http://www.cms.org

CMS OnLine web page.

Colorado Medical Society

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*Rates shown for 8 oz. overnight letter. Savings based on a FedEx 8 oz. letter to Region 8 ($16.25) plus $3.00 per package pickup fee. Rates subject to change.

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Address (no P.O. Box) _____

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Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

We have been delighted by the growth of Rocky Mountain Physicians Choice (RMPC) member enrollment in the past year in Southern Colorado, now numbering in the range of 10,000 participants. Numerous physicians currently have well over 100 members in their practice.

However, there have been major financial losses sustained during this time, and it is essential that we clarify and control the sources. Despite these losses, we have recently been urged to increase physician reimbursement to a level that would threaten financial failure if not balanced by dramatic cost reductions in other expenses. Our data does not yet fully identify all items of reasonable cost savings for each physician, such as consistent use of contracted reference labs and imaging sites, specialty referral trends, frequency of emergency room usage, hospital days impacted by convenience rather than medical necessity, etc.

In an effort to clarify these issues and allow continued viability of RMPC and fair physician reimbursement, we will be meeting with several primary care physicians in Southern Colorado over the next few weeks who have high patient volume and/or high expense RMPC practices. These contacts are intended to be mutually educational as well as resulting in change towards more cost effective practice if specific over utilization is identified.

Because of the urgency and importance of this effort, these meetings will be physician-to-physician (not staff-to-staff), brief, focused, and scheduled to fit the demands of the workday as much as possible. So, if you are a primary care physician in Southern Colorado, please let your staff know that we may be calling, and ask them to respond expeditiously. We must proceed rapidly and effectively together to balance, stabilize, and unify our efforts. Thank you for your continued support.

Introducing . . . Patty Mejia-Osborne, our newest staff addition at CPN. Ms. Osborne replaces Kathy Murphy who has accepted another position.



Patty Mejia-Osborne

Ms. Osborne will be in the CPN office on a shortened schedule, Monday through Thursday, from 9:00AM until 1:00 PM.

Prior to joining CPN, Ms. Osborne began her work in health insurance in 1993 in Pomona, California as a Benefits and Eligibility Coordinator with a local health plan. She then moved to Colorado where she worked with Antero Healthplans of Denver.

Patty, born in southern California, is married and has a 2-year-old son. Welcome, Patty Osborne, to Colorado Physician Network!

Retirement: Could be a 'Primrose Path'

Hidden Threats To A Successful Retirement

by
Simon Peter O'Hanlon, President
Preferred Financial Strategies, Inc.

Thinking about retiring from practice?

It happens to everyone sooner or later; however, physician retirement is occurring more frequently these days than ever before. Medical practice is losing some of its best at their prime, because of the paper work, headaches, increasing costs and diminishing rewards. We won't go into all the whys and wherefores. If **you** are thinking about retirement, here are some of the cautions and helpful guidelines available to you from some good sources.

First of all, an article by Simon Peter O'Hanlon, who is a Denverite and President of Preferred Financial Strategies. Simon Peter is a teacher, by profession, and he's carried this long-time work over into helping people in their retirement planning. This is not just about financial planning; there are many things that go along with finances that work toward a satisfying retirement.

Following this, we have reprinted an article from ***Medical Economics*** (May, 1994) which we first printed in 1995. The aspects of retiring, selling or closing your practice have not changed much, so the article is still very effective. It deals with all of the above elements and more.

Retirement planning entails a great deal more than dollars and cents and rates of return. Retirement planning is about continuing to live life in a meaningful manner. Did you know that retirement has three very important P's: Passion, Purpose, and Planning? Regardless of whether we are young with thirty years before retirement or older and standing on the doorstep of our golden years, each of these P's needs to be addressed as we prepare for retirement.

When we interview our clients, we ask each, "Other than their spouse and family what is the one thing in life for which they have a passion?" Passion is what drives us and gives us purpose. All too often we have had to leave our passions behind us because we had to build a practice, pay the bills, perfect our professional skills, rear our families, etc...And, for some of us our careers, which we are about to leave behind, have been our lifelong passion. Retirement provides us with a new opportunity to look back and reclaim old passions and/or the possibility to look forward and identify new passions that we could pursue during retirement. We will have the prospect of exploring new frontiers about ourselves and about our lives, during our retirement years, but only if we plan for it.

Take for example the physician, widely known, who couldn't wait until retirement, yet within eighteen months of selling his practice and heading out to pasture he died... Why? My belief is that he hadn't taken the time to identify a new passion in his life. Without that passion, his life had no meaningful purpose. Without the energy passion infuses into our lives, we will die sooner than later and not be able to meet, much less enjoy our own expectations during retirement.

Passion provides us with purpose in our lives, and each of us was created with the intent that we live our lives with purpose. A purposeful life does not end with retirement; in fact retirement provides us with a new beginning, new choices, new challenges. As medical professionals you have dedicated your lives to the purpose of fulfilling the Hippocratic Oath, rearing your families, and making real contributions to your communities. Purpose lives at the center of your committed lives. You have created a certain identity that has defined you for the last twenty-five to forty-five years. What happens to you when "suddenly" you are faced with a new life, one "without purpose" and one "without identity."

We were created with a purpose for a purpose. A life without it would be a life without meaning, without value, without fulfillment. Therefore, as you begin to prepare, put some time and energy into identifying that purpose: volunteering in an inner city clinic, becoming a mentor, dedicating your self to important social issues, spending two years in the Peace Corps or Americorps, focus on family, etc.

We ask each of our clients to begin to identify and address, as early as possible, what new purpose might nurture that sense of meaning and value in their lives as they begin to prepare for a fulfilling retirement. I would think that question even more significant for physicians as you approach your retirement planning challenges.

The process of planning emerges as the third 'P' in retirement and includes a myriad of topics, issues, and challenges. The first thing we must recognize is that planning is a process not an event. Secondly, just as in medicine, we have greater opportunity for real, planning success if we work with a trusted and qualified professional. In choosing that professional planning advisor, we have four responsibilities:

1) Choose an advisor that you trust and meets your qualifications.
2) Understand the advisor's professional perspective: is your advisor an insurance-based advisor, a stock brokerage advisor, or an asset management advisor. The advisor's perspective will often influence his/her recommendations.
3) Know how your advisor is compensated and be comfortable with it.
4) Resolve to be a proactive communicator with your advisor.

Among the traditional planning topics of investments, estate planning, asset allocation, risk management, etc., loom three crucial categories, a triple threat to retirement, that cannot be ignored: inflation, longevity, and taxes.

Regarding inflation, the math is simple and the impact dramatic. In order for a retiree to comfortably enjoy a taxable income of $50,000 per year, in today's dollars, he/she must have the equivalent of $1,000,000 in invested assets earning at a long-term average rate of return of 10%. Adjusting for an approximate thirty-year inflation rate of 5%, in fifteen years that income will need to double to $100,000 per year just to maintain one's standard of living. To provide that income that same retiree will need the equivalent of $2,000,000 in invested assets and $4,000,000 in thirty years.

In 1992 Dr. Michal Jazwinski, of Louisiana State University Medical Center stated, "that once we have the major genes in hand within the next thirty years, we will be in position to double, triple, even quadruple our maximum life expectancy of 120 years." (Life, 1992) He is not alone in his understanding of the potential impact of current genetic research. Pardon the pun but we are on the threshold of a whole new world. What if he is as much as fifty percent wrong? Within the next twenty-five years, many of us will have the choice to extend our life expectancies by thirty years, fifty years, or longer. And once we can no longer delay the vagaries of aging, the cost of maintaining our health and addressing our medical challenges will possibly triple our income needs and that of our families.

Finally, we come to taxes. In all our workshops and seminars we ask the attendees a series of questions about their experiences with taxes. Twenty years ago were you paying more or less taxes than you are today? The response is overwhelmingly predictable: more. Then twenty years from today do you expect to pay more or less taxes than you are today while maintaining your current standard of living? Again the response is overwhelming: more. If that is the case, then why have doctors been investing up to eighty to ninety percent of their retirement dollars in qualified plans, effectively deferring a lower income tax for a potentially, significantly higher income tax in the future? That lack of balance in the portfolios of most doctors exposes them to potentially huge tax liabilities during retirement. The retiree whose portfolio is eighty to ninety percent invested in qualified plans faces the prospect of paying up to fifty percent more in taxes than that retiree who enjoys a more balanced portfolio.

We believe that one of the areas in which we significantly help our clients is to embark on a very specific program of long-term tax planning. Usually, when investors tax plan, they focus on this year or last year. We need to educate ourselves regarding the fact that when we invest one hundred dollars in a qualified plan, only seventy dollars is our money. Thirty of it is the federal government's money. Furthermore, the better job we do of investing the federal government's money, when it comes time to distribute that money, the more the federal government keeps of ours. Think about it. The federal government is our senior partner in our qualified plans. Uncle Sam is in complete control of all the rules regarding the distribution and taxation of our money in our qualified plans. We help our clients become more balanced relative to enjoying retirement and maintaining their standard of living while paying less income taxes and less estate taxes upon settlement of their estates.

As you continue your planning process, give some thought to the three "P's" in retirement (Purpose, Passion, Planning), and take action to develop a long-term plan regarding the challenges of retirement's triple threat of inflation, longevity, and taxation during retirement.

Doctor: If you are considering retiring from full-time practice. . .

. . . remember you can't play golf every day, all the time. Stop to think about what you plan on doing in retirement, and then put ***volunteering your time and skills*** to a worthy, non-profit organization at the top of the list. It would be a wonderful use of your time and will allow you to keep your medical license active and your mind fully engaged.

If you don't have any idea how to find a place to volunteer, start with the Colorado Secretary of State's listings of the many non-profit organizations in Colorado. You'll find a place immediately.

Secretary of State
1560 Broadway, Suite 200
(303) 894-2200

Closing your practice: Start planning years ahead

By Joel H. Goldberg

Some of the most common questions received by the Colorado Medical Society revolve around retiring, closing or selling a medical practice.

Some of the best answers we have seen appeared in Medical Economics magazine in May, 1994. We have here reprinted that article.

It's a lot more involved than most doctors think. You have to consider your pension plan, patients, personnel, and insurance. Twenty years ago, Chicago OBG specialist Albert Gerbie told his five partners he'd retire at the end of 1993. To their surprise, he did. Since he'd had so much time to prepare, his departure went smoothly for him and the group.

In contrast, a New Jersey pediatrician telephoned attorney Cal Feingold of Hackensack recently, seeking help in closing his practice. "I don't like the way things are going in medicine. I want out now!" he exclaimed. The lawyer urged him to give it at least one more year. "If you hire an associate and eventually sell him the practice, you'll be much belter off financially," Feingold pointed out. "You'll have another year or two of income, and the sale price might be the equivalent of half a year's gross." But the pediatrician was adamant, although it meant losing the practice he'd built up.

Even so, he couldn't close from one day to the next. "Too often," Feingold explains, "a doctor doesn't know what's involved--for example, when and how to close out a retirement plan. And there are other matters to be taken care of, including your patients, office staff, patient charts and other records, and professional-liability coverage. That's why planning is essential."

A generous lead time is especially important if you're in solo practice or an expense-sharing arrangement and don't have partners to buy you out and take on your patients and other obligations. Like the pediatrician, you could forfeit your practice by retiring abruptly.

In contrast, consider the retirement planning of Louisville orthopedist Ronald Fadel. This spring, the 55-year-old surgeon reached an oral agreement with a group of orthopedists. "They're located at another hospital's medical campus a 15-minute drive away, and they're eager to expand into my hospital's market," Fadel explains. "They'll buy my practice two years from now and hire a young doctor to take over."

For three or four years after that, Fadel will see patients in the office two days a week. That's to keep patients coming back while the new doctor builds his census. "I'll give up surgery altogether, which will reduce my malpractice exposure," Fadel declares, adding that his new work schedule, with its reduced paperwork, "will get me out of the sphere of Hillary-Billary."

Partners: Update your buy-sell agreement

An ophthalmologist who'd left his partner called Medical Economics recently to inquire: "What's the average buyout price for a doctor in my field? I think my partner cheated me." We referred the question to practice management consultants. Their reply: "You should have gotten whatever the two of you most recently agreed to - nothing more, nothing less." The ophthalmologist and his former partner had never changed their original agreement, and he thought his share of the practice was now worth far more.

Obviously, it's wise to update your buy-sell agreement at regular intervals. But suppose the practice equity hasn't grown in value as expected? "If all you're going to get is trailing receivable, perhaps you need to sit down with your colleagues and talk about giving you more," says Chicago attorney Jamie Stuart. "Even though they don't have to, they may be willing to make some adjustments," he notes. "After all, they'll be in the same boat when they retire."

(Continued)

(Continued from preceding page)

One year ahead: Take care of the four "Ps"

Whether or not you expect to sell your practice, certain matters demand attention well ahead of time. These are your pension plan, patients, personnel, and professional-liability coverage.

Don't forget that you have other people's money in your practice's retirement fund. At least a year before leaving practice, consult your financial adviser to make sure you'll be able to pay off all your employees who are vested in the plan.

"Some of them won't be old enough to take a distribution," notes attorney Feingold. "You'll have to start collecting the appropriate forms and notices so they'll be able to roll over their funds. You'll also want to be able to use all your own money the way you intended."

Collecting bills will be a big priority. In the last six months before quitting day, concentrate on reducing accounts receivable so that most of what you've billed for will be in the bank. "Keep in mind that a patient who has been a reluctant payer in the past is going to be even more reluctant when you're no longer his doctor," attorney Stuart warns.

For that reason, don't be in a hurry to break the news to patients. Make it formal 60 days ahead of retirement, be sending a letter to every patient on your active list--usually defined as anybody you've seen in the past two years.

In the letter, explain when and why you're leaving practice, which colleagues you recommend, how patients can have copies of their charts transferred, and what your relationship with them meant to you. However, don't pass up the opportunity to say good-by in person as longtime patients come and go in your office, particularly those whom you see frequently for chronic problems and those who may need extra time to find new doctor. You can start these chats even before you send your letter.

With the letter, include an authorization form for the release of patients' medical records to another doctor of their choice. Keep a list of the patients you've notified, along with any envelopes that the post office returns to you.

It's also a good idea to follow up on pregnant and chronically ill patients, to make sure they've chosen other physicians and will continue to get proper care.

Even before the word goes out to patients, you'll have to tell your staff that you're leaving the practice. If you're solo and don't expect anyone to buy you out, it's a nice gesture to offer to help your assistants find similar jobs with colleagues or at your hospital, ideally to begin the day after you quit. For employees who don't latch onto a new job quickly, the advance notice will also allow time to switch their group health insurance to individual policies. Write each of them a letter of recommendation.

Also, determine how much extra pay you'll owe them for unused vacation time. If you're selling your practice to another physician or throwing in with an established group, determine whose responsibility such outlays will be.

Make sure your malpractice protection will continue. In general this will happen automatically if you have occurrence coverage. Just to be sure, check your policy.

However, if you're like the majority of doctors, you have a claims-made policy. To keep on being covered after retirement, you may have to buy tail insurance, also known as a reporting endorsement. Many carriers waive the premium for retiring doctors who satisfy certain conditions. Typical is the Illinois State Medical Inter-Insurance Exchange, which does this for physicians aged 55 or older who've been with the insurer for at least five consecutive years.

The cost of tail coverage varies greatly, depending on specialty and part of the country. Count on its being at least the following year's regular premium, and perhaps twice that amount or more. Find out well ahead of time what your carrier will charge, whether it will accept installment payments, and when the money will be due, so you'll have the cash available when it's needed.

At least two months ahead: Delve into the details

Whatever your plans, notify your state board of medical examiners. Tell the board whether you plan to practice in any other jurisdiction and whether you want to keep your license active or inactive.

Send word to your county and state medical societies, too. Be sure somebody at your local medical society knows where your patient records can be located. And even if you aren't a member of the American Medical Association, the organization needs to know your new professional status. It will use the information to update its Physician Masterfile.

Contact the Federal Drug Enforcement Agency and find out its procedurcs for turning in your DEA registration, along with unused DEA forms and controlled drugs. If you'll need your DEA registration, the agency will want your new address.

"Drugs that aren't controlled substances can be sold just like other supplies," says Chicago-based practice consultant Karen Zupko. "Sometimes a pharmaceutical company will take back unopened stock if it hasn't expired. Ask your detailer."

If you're retiring, check on what insurance and other benefits your professional organizations provide, and decide whether any of them need to be replaced out of your own pocket. You probably won't need to continue your life and disability insurance. But group health insurance will still be important if you're retiring before age 65 or if your spouse still has a few years until Medicare kicks in.

Don't forget all the business insurance policies you'll want to

(Continued on page 213)

Looking forward to retirement? Thinking about selling your practice?

Think early--and hard--about selling your practice. For doctors planning to leave an office-based practice, the first major decision will be whether to try selling it. Despite the accelerating trend to group practice, the majority of practitioners -- including 62 percent of internists, 58 percent of FPs, 60 percent of OBG specialists, and 48 percent of pediatricians - were in either solo practice or an expense-sharing arrangement in 1993, according to the Medical Economics Continuing Survey. Without partners to buy them out, these physicians have the following options: Let your practice wind down. In this scenario, you ease up gradually, practicing part time and giving up high-risk services such as surgery or deliveries. Many retiring doctors limit their practices to the office setting and stop taking calls. The trouble with this is that expenses won't fall in proportion to revenue; the difference - your net income will quickly dwindle. You'll still have to go through the practice-closing steps outlined in the accompanying article. And after you quit, you and your family will have nothing to show for your decades of hard work.

For all those reasons, few practice management consultants recommend winding down. "You should at least put your practice on the market and see what happens," advises Leif C. Beck of The Health Care Group in Plymouth Meeting, Pa. "It makes no sense not to try selling." Sell to a hospital. "Increasingly, hospitals are doing the buying," says Steven B. Enright, a financial adviser in River Vale, N.J. "You may want to look into that possibility first." There are drawbacks, however. If you retire, the successor the hospital hires may not give your patients the personal attention that you did. If you go to work for the hospital and are paid a percentage of your collections, your income may take a hit. Many practice management consultants feel that hospitals don't do a good job of billing and collecting for physicians' services, or managing their office staffs.

Then there's the psychological switch from private practice to employment " Think twice about accepting a job," advises retired internist Walter E. O'Donnell of Gloucester, Mass. "You'll get rid of some hassles, but it's not an easy adjustment for somebody in his 50s or 60s to start having a supervisor watch over him." Hire an associate who'll buy you out. This way, you can taper off for a few months to a few years while your patients get to know their new doctor. You can also avoid all the work involved in closing down your office, as detailed in the accompanying article. This option could be more palatable than working for a hospital, because you''ll retain your autonomy. On the other hand, you could have trouble finding a doctor interested in taking over a solo practice long enough to buy you out, what with the "bigger is safer" mind-set of the 90s sending more doctors into group practice. Merge with, or sell to, a group. Many large groups are snapping up small practices to serve as satellites. This would not only let you stay in private practice but also free you of many administrative responsibilities. And if you retire, the group could provide a home for your medical records, notes Health Care Group consultant Sandra McGraw. On the minus side, if you stay on, a merger could force you to change your practice style and pace. Chances are that with a large group, you'd become more heavily involved in managed care. Also, you'd be expected to fit into the group's "culture" and forfeit a certain degree of independence.

What's your practice worth?

The practices in most demand these days are in primary-care fields. If you're a specialist and depend on referrals, expect trouble selling.

Either way, your practice may fetch a lot less than it might have a few years ago. Chicago attorney Jamie Stuart attributes the decline in value to the rise of managed care. "If all the care you give is managed care, all you own is contracts," he notes. "Most contracts aren't transferable. Your successor will have to negotiate new ones on his own."

For this reason, a traditional attraction of a practice purchase - its patient census - is quickly fading in importance. Leif C. Beck, of The Health Care Group, which originated the Goodwill Registry, a respected guide to practice values, concedes that "the value of good will is much more conjectural than it used to be." In some areas, he says, good will may have no value, while in others it may range from 30 percent of annual practice gross (for a practice in a referral field) to 40 percent (for a primary-care practice).

Besides managed care and other health-reform activity, the federal government's enforcement of Medicare and Medicaid fraud-and-abuse regulations is depressing practice values. Hospitals are often reluctant to pay for anything that isn't a tangible asset - and that, of course, affects their decision to pay for good will. Some experts suspect that hospitals sometimes partially compensate for that by inflating the value of hard assets.

The message that practice values have dropped seems to be getting across. One surgeon, for example, recently agreed to a sale price of $160,000 - barely more than a third of his annual gross. Acknowledging that he has seen other physicians set much higher prices, sometimes at twice annual gross, he considers his own price "modest but realistic." He adds that greedy physicians aren't likely to sell as fast as he did.

(Continued from page 211)

cancel or transfer to the doctor or group that buys you out. There's fire and theft on your office, and liability insurance on the property. Whether or not this coverage is all under the same policy, keep it in force until your office is actually vacated--not just the last day you see patients there.

Keep your workers' compensation insurance in effect as long as anybody is still on your payroll. The same goes for any disability insurance or office-overhead insurance you carry. Then find out whether you're due a refund on the unexpired portions of those policies.

Several weeks before you leave practice, have your office manager or insurance clerk contact all the third-party payers you deal with--Medicare, Medicaid, Blue Shield, commercial carriers, PPOs, and HMOs-- and get instructions for turning in or changing your provider numbers. If payers will still be sending you payments after you close your office, make sure they know where to mail them.

You may want to arrange with one of your front-office people to collect your mail, deposit checks, and keep your bookkeeping up to date for a specified time. The employee is generally paid on an hourly rate for whatever time this takes. But if that doesn't seem practical, you may be able to arrange with your bank for a lockbox service, available at most large commercial banks, according to Judith N. Aburmishan, a Chicago area accountant and practice management consultant. The bank assigns you a post-office box number. You notify insurance carriers and patients with unpaid bills of this change of address. Once a day, the bank picks up your mail, opens it, and posts any payments to your account. At least once a month, the bank mails you all the explanations of benefits and other correspondence. While there's a fee for this service, it may be less than you'd pay the employee, Aburmishan says.

Two months before closing, or whatever notification period is specified in your office lease, tell your landlord you won't be renewing. Also, make arrangements to turn in any leased equipment. Tell the local utilities when you plan to vacate and will need a final meter reading. Cancel (or forward) any magazine and journal subscriptions that come to the office. And let the post office know your forwarding address.

After you close down: There's still more to do

While you won't have your practice's patients, you'll have their medical records if you retire. Many practice management consultants recommend holding on to all original charts indefinitely - not only in case of a malpractice suit years later, but also because you could be audited by Medicare or Medicaid. Also, if you've treated children, they'll need access to their immunization records.

But where to keep all those charts! They'll clutter up your attic or garage. You also may not want the work and expense of copying them and forwarding the copies to other doctors.

One good bet is a commercial storage facility, usually listed in the Yellow Pages under ""Office Records Stored." To archive a doctor's medical records, one such facility in New Jersey charges 22 cents per 15-inch-long box per month. If you drive up with 200 boxes, for example, it will cost $44 a month to have them bar-coded and filed away. "Access is no problem," says a spokesman for the facility, "but there's a fee of $1.70 each time we pull a box for the customer, and an $11 fee to deliver a record to him." Archive companies will also copy records for you.

Another option is to have your records microfilmed; many archive firms will do that, too. The cost up

(Continued on page 214)

One doctor's goodbye to his patients

Your farewell letter to patients should include such things as the date you're leaving and how patients can obtain their records and continued care. But the letter's style and warmth depend on you--and on how you ran your practice.

"That may vary by specialty and by where the practice is located-- in New York City or a small town in Nebraska," notes Chicago management consultant Karen A. Zupko. The following letter from one OBG specialist is markedly warmer than the letters used as examples by most medical societies

An open letter to my friends and patients:

After 40 years of practicing obstetrics and gynecology, I have decided that it is time to retire from patient care as of Dec. 31, 1993.

I have truly enjoyed caring for you and your family, and because your welfare is my utmost concern, I wish to make this transition as easy and efficient as possible for you. As you know. I have practiced most recently with Drs. Melvin Gerbie, Michael Halpern, Howard Arof, Mary Ellen Farusone and Nanette Rumsey. They have been exceptional partners as well as superb physicians, and I firmly believe they will continue to give you excellent medical care. If this does not meet with your approval or needs. We will be happy to arrange for transfer of a summary of your records to whomever you designate.

The safe delivery of newborn babies has been the most exhilarating experience in medicine for me. The care of women through all life's phases has been most fulfilling, and you have helped to make it so.

Most sincerely,

Albert B. Gerbie, M.D.

(Continued from page 213)

front is high, but you'll pay far less for storage.

A third possibility is rental of a "mini-storage" space. However, archiving or microfilming is likely to be a better deal. In mini-storage, you'll typically pay $64 to $82 a month for a 5 by 10 foot room.

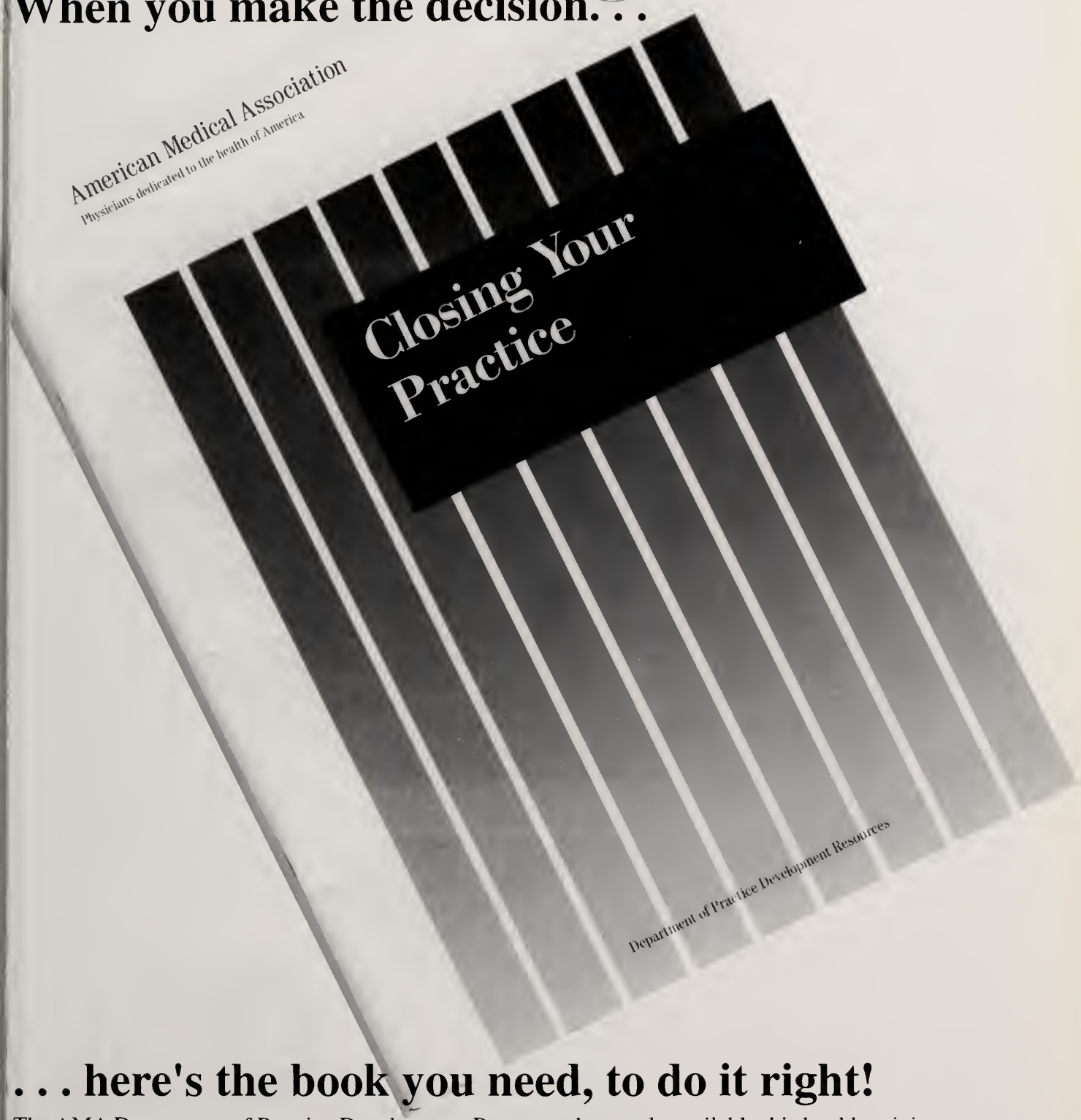
Back up computerized patient-account records on diskette or tape, advises consultant Karen Zupko. If your practice isn't computerized, keep the current year's paper records until tax-filling deadline two years hence- for instance, you'd hold on to 1994 accounts until April 15, 1996. This is to let patients verify medical expenses claimed on their tax returns, and to let them file amended returns.

There'll be other records to keep: Save all your old malpractice policies until all statutes of limitations have expired. Employment and earnings records generally must be kept for three years; your accountant or lawyer can tell you what's required in your state. Federal law requires you to keep records of employees' on-the-job exposure to bloodborne pathogens for the duration of employment plus 30 years, according to Mark Kropiewnicki of The Health Care Group in Plymouth Meeting, Pa.

Keep your office checking account active for three months or so, to allow you to pay any bills that straggle in. Once most checks have shown up on the monthly bank statements, you can close it.

Finally, decide which services to keep in place. If you've planned carefully and notified patients early enough, you shouldn't have to keep your office open or pay assistants, says Karen Zupko. However, she suggests keeping your answering service for three to 12 months, to redirect calls. "You can write the operators a short script to read, telling patients whom to call for copies of records, or other doctors how to reach you," Zupko says. And so that patients can call to get their records, keep your Yellow Pages listing for a year after you close.

When you make the decision. . .



. . . here's the book you need, to do it right!

The AMA Department of Practice Development Resources has made available this booklet giving you the fiscal, legal and ethical answers to all those questions when you decide to close your practice. You can order the book by calling 1-800/621-8335. The order number is OP381689RY. Price of the book is $19.95 for AMA members, $24.95 if you are not a member.

CU Med School student receives AMA award

Sharon Lisa Stein was one of 50 outstanding young medical professional honored today by the American Medical Association (AMA) Foundation at the AMA's annual National Leadership Development Conference in Miami, Florida.

The AMA Foundation's Leadership Awards recognize 25 medical students and 25 resident and fellow physicians for their exceptional leadership among their peer and achievements in non-clinical community activities.

Ms. Stein is actively involved with numerous programs emphasizing care for children with chronic illness. She directs Camp Wapiyapi, a camp run completely by volunteers which provides a week in the Colorado mountains for children with cancer and their siblings. She also directs the Buff Buddy program, a mentoring program for children with sickle cell disease and their siblings. She is a third year medical student at the University of Colorado School of Medicine.

"The AMA Foundation seeks to honor and recognize young medical professionals who have demonstrated their commitment to medicine and community service," said William H. Mahood, MD, FACP, president of the AMA Foundation.

The AMA Foundation Leadership Award provides recipients with the opportunity to attend the AMA's National Leadership Development Conference, to meet other medical leaders, and to learn about many of the most important health care issues facing medicine. The AMA Foundation, a 501(c)(3) organization, is the philanthropic arm of the American Medical Association, dedicated to serving the needs of physicians and patients.

Colorado Medical Society Alliance Annual Meeting

The Colorado Medical Society Alliance annual spring meeting was held April 13 and 14, 2000 at the Valley Country Club in Aurora. AMA Alliance President Ann Hansen, from San Luis Obispo, California, was the guest speaker and installing officer. Thursday afternoon Ann Hansen gave a workshop on enhancing skills in working with members and leadership and committee development. Following a CMSA board meeting, the day ended with a dinner at which special guests included CMS President Dr. Jack Berry as well as Dr. Jerry Merenstein who represented the CU Medical School.

CMS Annual Meeting Challenge

At the CMS Annual Meeting in Beaver Creek in September, 1999 CMSA President Joyce Wilson challenged members of the House of Delegates to join the Alliance in working together to do more for the family of medicine. The record sale of basket raffle tickets as well as a substantial contribution from a physician led to sizeable donations in the two AMA Foundation checks donated to the medical school. Ann Hansen joined Dr. Jack Berry and Joyce Wilson in presenting checks for $3,510 for the Medical School Excellence Fund and $6,544.70 for the Medical Student Assistance Fund

Installation of Officers

On April 14 Ann Hansen installed the Alliance officers for 2000-2001. They are: President- Joyce Wilson, Metro Denver; Secretary- Gay Walker, Mesa; Treasurer- Maribeth Berry, Member-at-Large. The CMSA Alliance theme for the coming year is, "We can do more together." While it is not original, it is true. All CMS members are invited to join the Alliance and accomplish more, because we work together on projects from raising money for the AMA Foundation to supporting the Colorado Coalition for the Medically Underserved to lobbying legislators.

CMS Online

http://www.cms.org

Legalities Of Using And Maintaining Computerized Medical Records In Colorado

This is a one-day seminar designed for hospital administrators, health care providers, medical records professionals, coders, mental health professionals and directors of health information systems in the medical field as an explanation of the laws and their impact on the record keeping process.

For many member physicians of Colorado Medical Society , employees handling medical records and coding, using new technologies such as the computer and internet need to be aware of what's happening in the arena of electronic medical records.

The seminar will be held June 15, 2000, at the Radisson Inn Colorado Springs North, 8110 North Academy Boulevard, Colorado Springs, CO. Registration is 8:30 a.m. to 9:00 a.m., and the seminar is from 9:00 a.m. until 4:30 p.m. Lunch is not provided.

Included on the faculty* are:

Natalie Hanlon-Leh and Ann C. McCullough of the law firm of Faegre & Benson LLP;

Richard L. Murray. Jr. of the law firm of Montgomery Little & McGrew; and

Michael S. Victoroff, M.D., of Aetna US HealthCare.

This seminar meets the criteria of the American Association of Medical Assistants and is approved for 0.6 CEUs. The program has been granted prior approval by the American Health Information Management Association (AHIMA) for 6.0 continuing education hours. It satisfies the requirements of the Technology core educational content area. Sponsors of the seminar remind readers that these educational approvals in no constitute an endorsement by the AHIMA of the program content or the program sponsors.

Benefits of the program:

Maintaining confidentiality of patient treatment records and other information is becoming increasingly complex. The use of computers, the internet, e-mail and faxes as part of medical practices makes it all the more important that healthcare practitioners and others who handle medical records be informed about the options and issues regarding electronic medical records and be proficient in using new technologies and understanding safeguards which may help protect confidential information. Medical professionals are expected to be not only proficient in the healthcare arena, but also capable of interacting and utilizing various types of computer equipment and programs.

This program will focus on issues which offices and institutions need to deal with to be able to successfully manage electronic medical records.

Topics to be discussed include:

- Available Technology
- Confidentiality Of Common Electronic Systems
- Standards For Electronic Medical Records
- Confidentiality Of Electronic Communications
- Electronic Records In Court

Who Should Attend?

This seminar is designed for hospital administrators, health care providers, medical records professionals, coders, mental health professionals and directors of health information systems in the medical field as an explanation of the laws and their impact on the record-keeping process.

Information included herein has been supplied by the program sponsors and by Lorman Educational Services of Eau Claire, Wisconsin. Colorado Medical Society does not accept responsibility for any of the information or the content of the seminar itself.

* Robert L. Murray, Jr., is a member of the firm which serves as legal counsel to the Colorado Medical Society.

Michael S. Victoroff, MD, is the Chair of the CMS Medical Informatics Committee.



COLORADO FOUNDATION FOR MEDICAL CARE

Increasing Breast Cancer Screening:

Benefiting Patients through CFMC-Provider Collaboration

by W. William Schluter,, MD, MSPH; Tim Byers, MD. MPH; Lisa Ramsey, MPH; Meghan Warren, MPH

"Despite the fact that the rate of mammography is increasing, obstacles remain . . ."

In December, 3,229 primary care providers were invited to participate in a CFMC-initiated project which offered to provide physician practices free, postage-paid mammography reminders for Valentine's Day. Only 94 physician offices chose to participate. Participating practices reached approximately 10% of Colorado's Medicare beneficiaries.

To evaluate the usefulness of mailed reminders, CFMC recently completed two randomized, controlled trials to evaluate the benefits of sending reminders directly from CFMC. Both trials targeted women enrolled in Medicare part B but not in an HMO. Women were randomized into either a mailed reminder intervention group or a control group. Medicare claims data were used for analysis.

One trial targeted all women in 21 rural counties. A claim for mammography in the 24 months following the intervention was found among 49.6% of the 1,143 women who received the direct mailed intervention, compared to 42.1% of the 1,889 women in the control group (a 7.5% difference, $p<.0001$). The second study targeted only those women who had not had a mammogram in the prior 2.5 years in six Metro counties. A claim for mammography in the 12 months following the intervention was found among 12.4 % of the 4,405 women who received a direct mailed intervention, but only among 9.6% the 1,121 women in the control group (a 2.8% difference, $p<.01$).

From these results we learned that mammography reminders mailed directly from CFMC can result in about a 15% higher mammography utilization rate over 24 months among all Medicare beneficiaries, and about 23% over 12 months among beneficiaries who have not received a screening in the past 2.5 years. While encouraging, we know from previous research that the rates would have been higher had the message come from the recipient's physician.

Despite the fact that the rate of mammography is increasing, obstacles remain which prevent women from being screened. Older women, women who live in rural areas, and minorities are especially at risk. A physician recommendation remains the single most important factor influencing a woman's decision to have a screening mammogram. Mailed patient reminders are an opportunity to reach the women most at risk. A recent meta-analysis by the RAND Corporation noted that "patient reminders that are personalized or signed by the patient's physician are more effective than reminders that are generic," a finding that is consistent with the ideal of a physician recommendation.

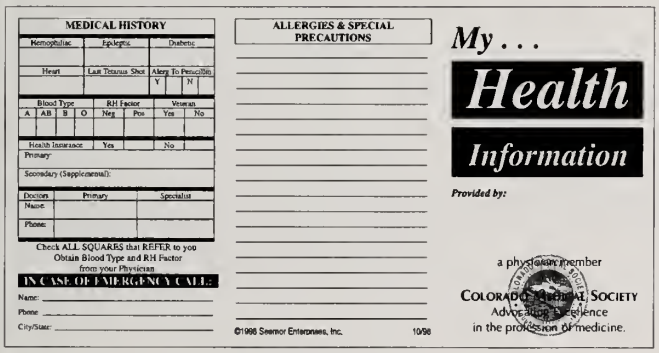
If you have reminder systems in place within your office, hospital, or mammography center, great! Nevertheless, these systems rarely capture the women at greatest risk (i.e., those who do not receive routine preventive care or those who have never been screened). Your collaboration in future CFMC sponsored reminder programs provides an opportunity to encourage screening among women at highest risk, at little or no cost to your practice.

Physicians Advocating for the patient

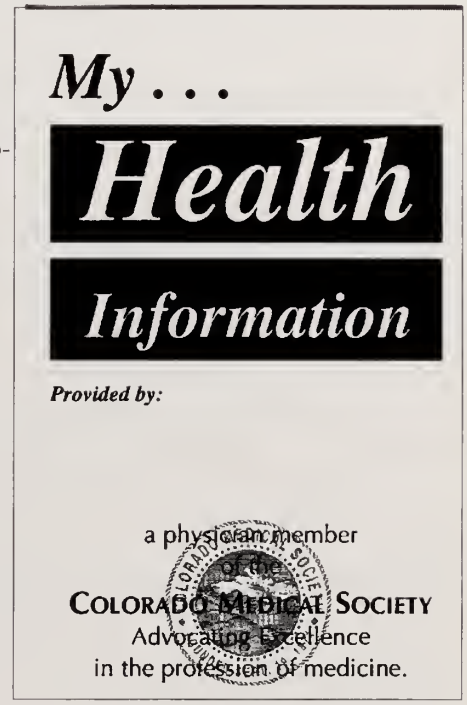
Every day we are reminded that patients of all ages do not follow their physician's directions very well. We hear of patients taking seriously conflicting substances, such as taking an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among the older citizens.

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of the medications they are prescribed, what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions.

CMS Member Services had come up with a handy device that can be supplied your patients for this very job, and at a low cost. The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as your medical needs and will hold up a long time.



1/2 of actual size



Actual size of folded card

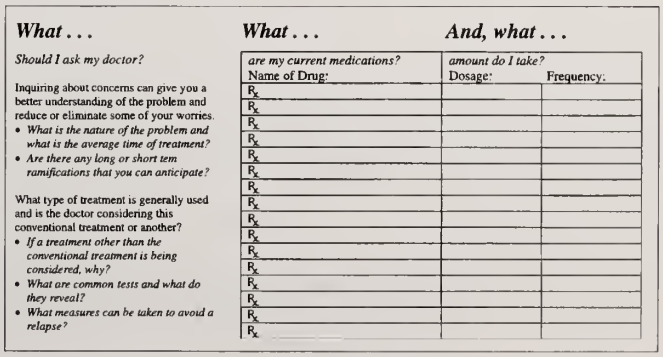
These health/medication records allow you to place a doctor identification on the front in a space 3/4" deep by 2" wide.

We at CMS feel that your patients will appreciate you for providing them with this, and will be a constant reminder of the quality of care and concern you have for their healthy well-being.

If you would like to try these cards, they can be ordered in lots of 100 @ $0 .40 ea = $40.00. This includes postage paid delivery. Sorry, but we cannot handle any orders less than 100 right now.

The cards are on hand and available now from CMS. They are an exclusive CMS member service. In time, they will be widely available, but for now, CMS is the only place you'll find them.

If you wish to order, send payment in advance to CMS, Member Services, P. O. Box 17550, Denver, CO 80217-0550. Delivery will be within the week.



1/2 of actual size

Out of prescription pads?

Who can you trust to print these important documents? Trust the Colorado Medical Society Member Services.



John Smith, MD
1234 Unknown Drive
Denver, CO 80210
(303) 555-5555
DEA # _____

Member of the Colorado Medical Society

Name: _____ Age: _____

Address: _____ Date: _____

℞ _____

_____

_____

_____

❑ Label
❑ No Generic
❑ Generic OK

Signature: _____
John Smith, M.D.

Refill 0 1 2 3 4 5 6 Times

Physicians advocating for their patients for 129 years

To order your Rx pads, please fill out the form below with your information and return it to: Colorado Medical Society, P. O. Box 17550, Denver, CO 80217-0550, ATTN: Member Services Dept. We **CANNOT customize** the printing of prescription pads. They will be in the same form and content as the sample shown here. Payment must accompany order. Make checks payable to Colorado Medical Society. Questions: call (720) 859-1001 or 1-800-654-5653. Ask for the Communications Office.

Name: _____
(please specify M.D. or D.O.)

Address: _____
(35 character maximum, including spaces)

City: _____ Zip Code: _____ _____ Phone: _____

Plain paper or NCR Rx pads are available. Plain paper consists of 100 sheets of 20 lb. stock paper, printed with the personalized information you supplied above, and padded. NCR sets allow you to retain a copy of every Rx you wite. Shipping and handling is included in the cost. **To order, check below.**

PLAIN PAPER PADS

❑ 10 pads for $9.25 ❑ 20 pads for $16.25 ❑ 30 pads for $22.95 ❑ Other (please call for prices)

NCR SETS

(These are not padded. Sets include white original plus a pink second-sheet.)

❑ 1000 sets for $31.20 ❑ 2000 sets for $62.40 ❑ 3000 sets for $93.60 ❑ Other (please call for prices)

Order today and let your patients know that you are a proud member of the Colorado Medical Society.

COLORADO MEDICAL SOCIETY

"Advocating excellence in the profession of medicine"

May, 2000

Dear Physician,

The Colorado Medical Society wishes to survey our members regarding use of **computerized prescription-writing programs**.

CMS is concerned with the recent report of the Institute of Medicine regarding medical errors[1], especially in regard to **medication error**.

While physicians are but one link in the chain of events that can lead toward medication error, we are an important link and have an opportunity to demonstrate leadership in error prevention.

Computerized prescription order entry "is effective in reducing medication errors. It eliminates problems with poor handwriting as well as the need for transcription. Computer entry removes a step that is frequently tied to medication errors: incorrect interpretation of the order by the person transcribing it. Through on-line prompting, computerized order entry can provide information of the drug and the patient at the time the order is entered, which further reduces the potential for error."[2]

Most computerized order entry systems are found in hospitals, although several programs are available for the office, either as stand-alone programs or as web-based services that can transmit prescriptions directly to pharmacies. CMS is unfamiliar with the popularity and utility of such programs, and would like to learn about our member's experience with them.

Please take a minute to respond to the **brief questionnaire** that accompanies this letter. We will share the results with our members in the near future.

Thank you,

Jean Kutner, MD
Dennis Waite, MD
Co-chairs
CMS Accountability Committee

[1] Kohn, L, Corrigan, J and Donaldson, M, Eds, , *To Err is Human: Building a Safe Health System*, Institute of Medicine, 1999

[2] Cohen, MR, Preventing Dispensing Errors, in Cohen, MR, Ed., Medication Errors, American Pharmaceutical Association, Washington, DC, 1999, pages 9.9 – 9.10.

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(720) 859-1001 or 1-800-654-5653 • FAX (720) 859-7509 • CMS web page www.cms.org

Computerized Prescription Writing Survey

1) Have you used any computerized prescription-writing programs in your office?
   a) _____Yes (Please complete the following questions)
   b) _____No (Thank you. Please return the survey)

2) How many programs have you tried?
   a) _____One
   b) _____Two
   c) _____Three or more

3) Do you use a program now?
   a) _____Yes
   b) _____No
   c) Which program do you use?(optional)_____

4) How easy to use is your current program?
   a) _____Extremely easy
   b) _____Somewhat easy
   c) _____Somewhat difficult
   d) _____Very Difficult
   e)
   Comment(optional) _____

5) How expensive is the program?
   a) _____Very expensive
   b) _____Somewhat expensive
   c) _____Somewhat inexpensive
   d) _____Very inexpensive
   e)
   Comment(optional) _____

6) What is the greatest **advantage** of the program?_____

7) What is the greatest **disadvantage** of the program?_____

8) May we contact you for more information?
   a) _____Yes (please supply contact information below)
   b) _____No

Thank you.

Please return the survey to:
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Accountability Committee
P.O. Box 17550
Denver, CO 80217

Or fax to (720) 859-7509

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PUEBLO, CO - BE/BC physician needed for hospital based occupational medicine clinic. Excellent compensation and benefit package. Contact Chris Hildebrant (719) 475-9496 send resume to 1633 Medical Centerpoint, Suite 103, Colorado Springs, 80907 12/1199

ROCKY FORD – LOWER ARKANSAS VALLEY - Seeking FP to join small primary care group practice with three offices plus satellite. Breadth of FP, with OB optional. Competitive salary guarantee and fringe package. Collegial atmosphere, great recreational opportunities, good schools and economical housing. Potential for loan repayment. Prefer female. Contact M.J. Berg, MD or Randy Evetts, MPA, (719) 254-7421, fax (719) 254-6966, E-mail MJberg@iguana.ria.net. 06/0300

MEDICAL DIRECTOR-Part-time for Denver based HMO. Licensed physician with good knowledge of evidence-based medical practice for evaluation of appropriate care. Contact Charles Barta, MD, Community Health Plan of the Rockies, Inc., 400 South Colorado Blvd., Suite 300, Denver, CO (303) 355-3220 ext. 3240. 04/0300

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Call Laura at (303) 776-1532 03/0500

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BOULDER - EXCELLENT OPPORTUNITY for Board Certified MD in Urgent/Family/ Occupational care. Reply to Medical Director, Meadows Medical Center, PC 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 04/0200

INTERNAL MEDICINE PRACTICE available in 6 to 12 months. Located in southwest Denver, Lakewood, Littleton area. Well-established practice of 22 years. New office suite in med/dental building. If interested, write to Box A, CMS, P.O. Box 17550, Denver,CO 80217-0550 06/0300

COLORADO SPRINGS - Occupational Medicine seeking qualified individual for full service established practice. Excellent compensation and benefits. Contact: Lynette at (719) 260-9797 04/0400

FP BC/BE to help staff rural practice. Opportunities in western NE. Part time and full time positions available. Excellent pay and compensation. Contact Michelle at (303) 655-0737 or (303) 655-0909. 03/0600

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SOUTH CENTRAL CO - We have wonderful opportunities for BC/BE physicians in: orthopedics, OB/Gyn, Family Pr. w/OB, Urology, and Internal med. Small town, recreation and family values. Visit our website: www.slvmc.com Fax CV to Leanne Pressly at (719) 589-8112 06/0400

EXCELLENT OPPORTUNITY for a BC/BE Family Practitioner to join a forty-two physician, well established multi-specialty group. Position will serve as the third physician in our Urgent Care Department. Competitive starting salary with an incentive program. Excellent corporate fringe benefits plan. Longmont, Colorado is located 45 miles north of Denver in the beautiful front range of the Rockies. Visit our website at www.Longmont Clinic.com. Contact: Lori Spahn, Longmont Clinic, P.C., 1925 W. Mountain View Ave., Longmont, CO 80501, fax: (303) 444-1588, phone: (303) 651-2373, E-mail: longmontclinic@yahoo.com. 03/0400

SOUTHERN COLORADO - Group of 3 Internists looking for a 4th BC Internist to join them in hospital and clinic practice, call every 5th. Be part of a nationally recognized, rural, diverse practice managing a JCAHO accredited community health center. Competitive salary, benefits, and time off to enjoy surrounding Rocky Mountains. Please forward Curriculum Vitae to Antonio Gurule, Director of Human Resources at Valley-Wide Health Services, Inc., 204 Carson Avenue, Alamosa, CO 81101. gurulea@VWHS.org. NO J-1 Visa opportunities. 03/0400

CONIFER,CO - Very busy Family Practice clinic in the community of Conifer needs a B/E, B/C Family Physician w/o OB ASAP. Guarantee for first 3 months. Call Sullins and Associates at: (303) 986-1909 or Fax CV to (303) 986-1509. 02/0500

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WHEATRIDGE,CO - Successful Cardiology clinic in Wheatridge needs a B.E., B/C Cardiologist, Non-Invasive, Non-Interventional ASAP. Competitive compensation package is offered. Call Berry at: (303) 986-1909 or fax CV to Sullins & Associates at: (303) 986-1509. 02/0500

FAMILY PRACTICE - EAGLE COLORADO Eagle Valley Medical Center, a well-established multi-specialty clinic, seeks second full time, experienced FP. The 4 day per week position offers a competitive salary and benefit package with a negotiable call schedule. The Eagle/Gypsum community is located only 30 minutes from both Vail and Glenwood Springs, where outdoor recreation abounds with first-class skiing, hiking, biking and more. Please contact: Alice Sundeen, Valley View Hospital, 1906 Blake Avenue, Glenwood Springs, CO 81601 (970) 928-2523 • FAX (970) 945-2073, E-mail asundeen@ruralhealth.org

LAKEWOOD - Busy pediatric office has Immediate opening for Pediatrician. Call (303) 233-7469 ask for Dr. Weiss, Anita or Jill. 03/0600

COME LIVE AND WORK IN FORT COLLINS. Four Doctor Family Practice seeking BE/BC Associate for fall 2000. Competitive salary and benefits. Fax CV's to Dr. David Ottolenghi @ (970) 493-6643 or call (970) 221-3855. 03/0600

PHYSICIANS BC/BE IN EM OR FP to join group which staffs rural and mountainous area emergency rooms/urgent care clinics throughout Colorado. Numerous travel opportunities without relocation, scheduled around your availability. Contact Michelle at (303) 655-0737 or (303) 655-0909. 03/0600

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If you are currently not receiving the newsletter in your office, please copy this form, complete it and **FAX** it to Marilyn Rissmiller at (720) 859-7509, or mail it to P. O. Box 17550, Denver, CO 80217-0550.

Practice Name _____

Specialty _____

Practice Address _____

_____

Practice Phone _____

Practice FAX _____

E-Mail Address _____

Office Manager's Name _____

Office Manager's Address (if different than practice)

_____

_____

Names of physicians in this practice group

_____

_____

_____

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

When he was elected President, his name was immediately entered in "Who's Who."

The day after he finished his term fo office, he became "Who's He?"

I have my own "Who's He?" list.

John M. Wood, Englewood
Kenneth A. Platt, Westrninster
Kenneth A. Kahn, Boulder
Joseph S. Pollard, Colorado Springs
Carl H. McLauthlin, Denver
William S. Curtis, Boulder
Robert B. Sawyer, Denver
Ray C. Witham, Craig
K. Mason Howard, Denver
Frederick A. Lewis, Jr., Denver
Merlin G. Otteman, Fort Collins
W. Gerald Rainer, Denver
Richert E. Quinn, Greeley
Richard F. Bedell, Boulder
Theodore R. Sadler, Jr., Denver
Robert D. Hartley, Greeley
John F. Farrington, Boulder
John A. Sbarbaro, Denver
Harrison G. Butler, III, Durango
Leigh Truitt, Denver
Wm. Carl Bailey, Denver
David C. Martz, Colorado Springs
Joel M. Karlin, Lakewood
M. Ray Painter, Jr., Denver
Gary D. VanderArk, Englewood
W. George Shanks, Grand Junction
Jack L. Berry, Wray
There are thousands others; these are just Presidents of CMS.

I remember telling Dr. Fred Lewis that as he grew close to the end of his term. He laughed. . . outwardly. I never knew what he really felt about my comment. It was a joke, but there was a lot of truth to the statement. Of course, I told that to a number of our presidents.

It's certainly interesting to go back and consider each one under whom you've served. I do that every once in a while, and it's not a bad thing to do. Each president of CMS I have known and worked for has been different in his "official" manner and conduct as well as his "unofficial" side. Many people over the years have asked me how in the world a staff can work for an organization, knowing that the personality, character and temperament of the organization is going to change **every year** with a new president. Of course, it has always been toughest on the exec; for me, it's just been a new challenge each year. I've grumbled some about what I was expected to do in the new administration, but my grumbles soon turned to mumbles as the year progressed and I watched the president learn the ropes, learning not to be such a harsh critic of himself, easing the nervousness in his job.

No, I can't say a bad thing about any of the men (and they have all been men) who have held this office since I've been employed by CMS. The first one I worked for was Dr. Bob Sawyer. Of course, I had known Bob before I came here, and that made a difference. During that same year, I met and immediately liked Dr. Bill Curtis who preceded Dr. Sawyer. I've always told both of them it was their collective faults that I came to work here, so for whatever has happened since I can not be held responsible. As I recall, it was in Dr. Curtis' term that the CMS reorganization commenced. I had met Drs. Joe Pollard and Carl McLauthlin in 1976, when I had done some things with DMS Exec. Pete Morstad and his assistant, Bob Hahn. They were also great individuals. Of course, it's lots of fun to see Dr. Pollard and Dr. Curtis nowadays when we do meet.

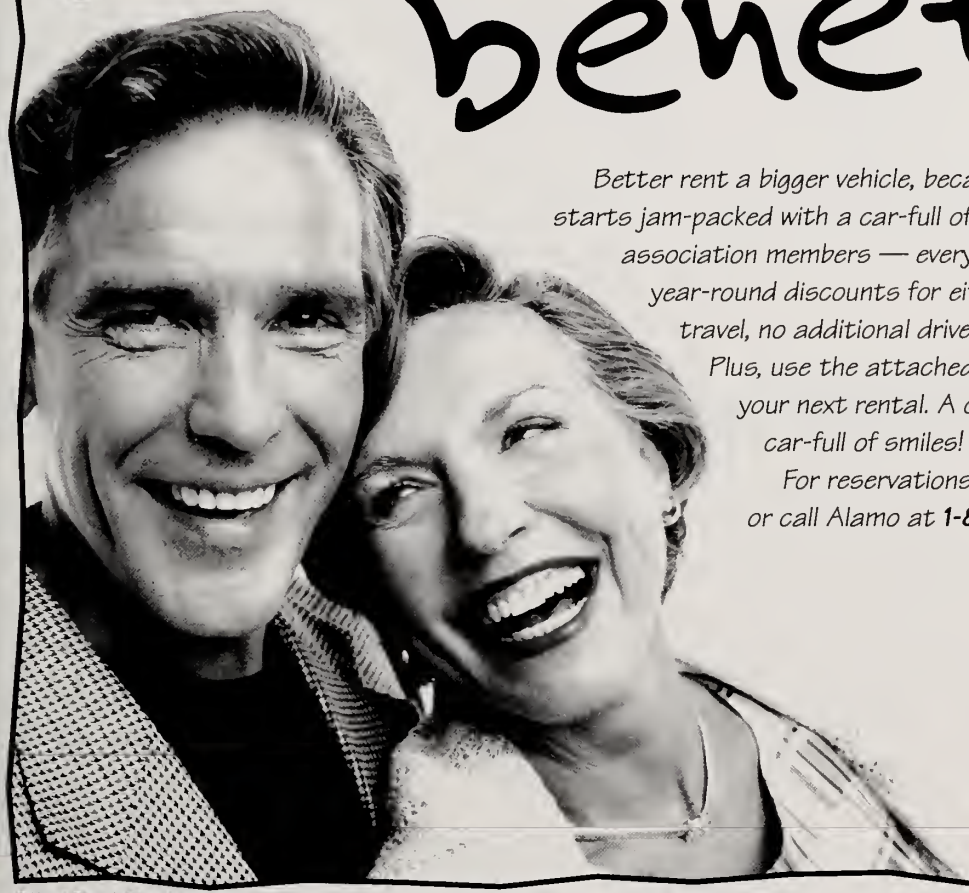
It wasn't long after that Dr. Ray Witham came over from Craig as CMS President. He always stopped in to see me when he was "in office". One day he came in and we cha`tted and he noticed I had a red spot on my left eyelid. He asked me about it and I said I thought it was a sty, and it was causing me a headache. He was genuinely concerned and advised me to "go see a doctor." I said "Thanks" and he left my office. About 20 seconds later he came back in and said "**I'M** a doctor. Let **me** look at that."

When new presidents take office, I can see why it is easy for many of them to forget that they are physicians because they are so overwhelmed with their new responsibilities.

There were fun times and tough times, and I've never stopped enjoying my job. I still thank Don Derry, Pete Morstad, Bob Hahn and all the rest of you for taking me on.

Yes, I know. There were more than one or two of you who, when you first took office, offered to show me the door if I didn't shape up, but we all got over it in a while . . . (well, at least **I** did).

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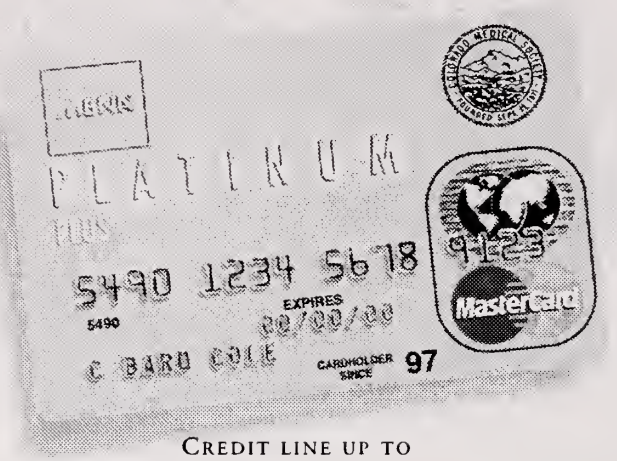
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Other income‡ +$,

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anged employers in the last three years.

X _____ Date / /

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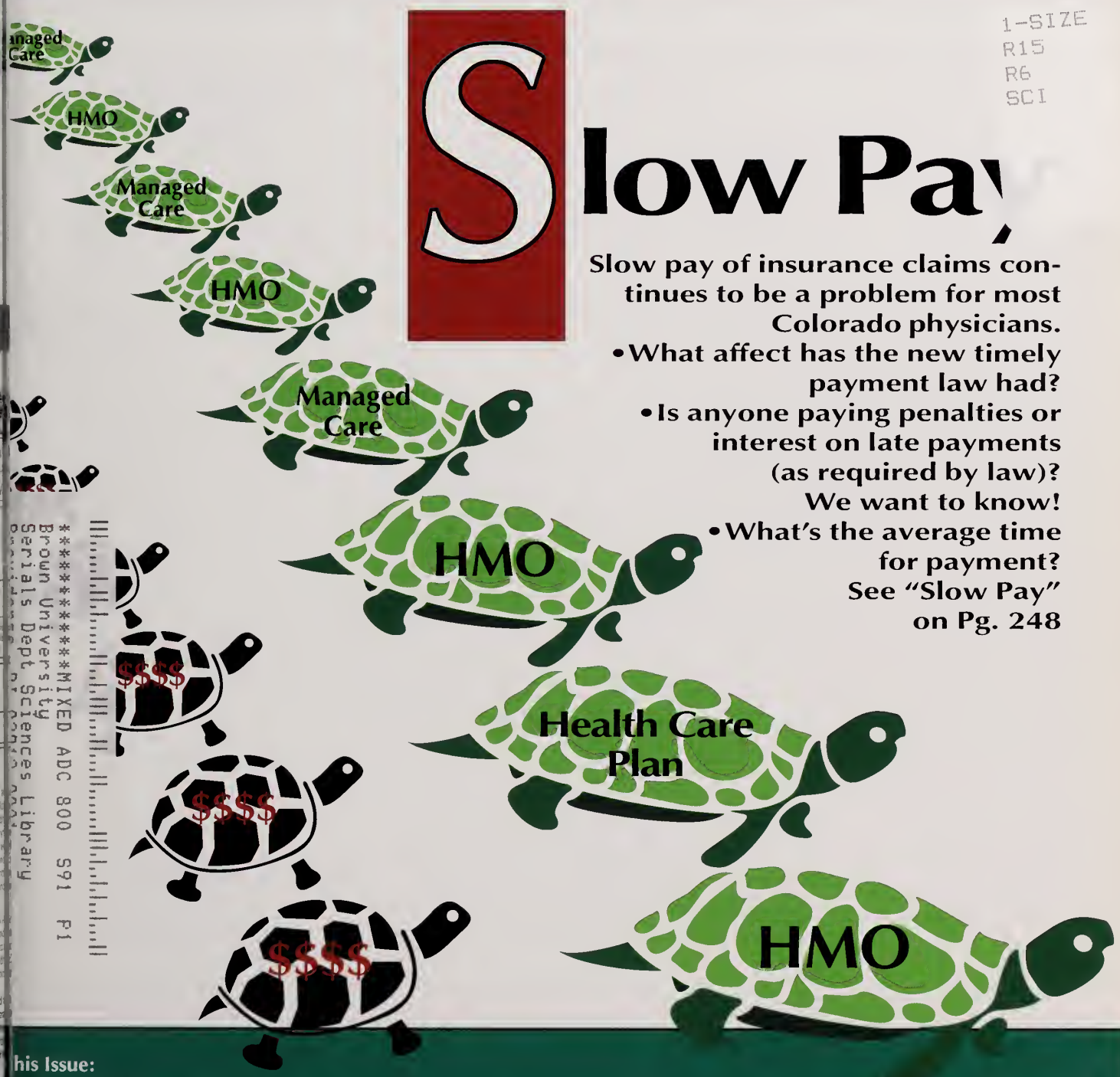
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Slow Pay

Slow pay of insurance claims continues to be a problem for most Colorado physicians.

- **What affect has the new timely payment law had?**
- **Is anyone paying penalties or interest on late payments (as required by law)? We want to know!**
- **What's the average time for payment?**

See "Slow Pay" on Pg. 248

his Issue:

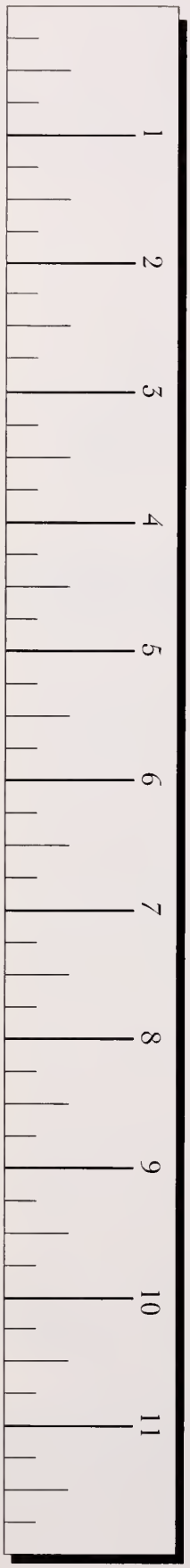
Medical Professionalism - by Dr. Jack L. Berry, MD, President, CMS ..... **page 233**

Medical Marijuana: Bad Medicine-Bad Law - by Drs. Joel Karlin & Jack Berry ..... **page 240**

Medical School: 100 and still counting - by Richard Krugman, MD, Dean, CU Medical School ..... **page 242**

Medical Healing: The Wounds Are Healed - by John L. Lightburn, MD, CMS Historian ..... **page 245**

Medical Payment: Slow Pay by Marilyn Rissmiller, Program Manager, CMS Health Care Financing ..... **page 248**



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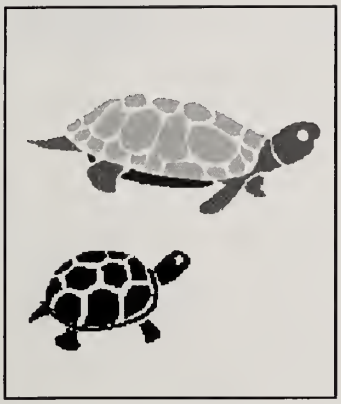
* Certification for these elements is considered current and in good standing until August 20, 2001 for managed care organization (MCO) and managed behavioral health organization (MBHO) practitioners. The National Committee for Quality Assurance is an independent, non-profit organization that certifies credentials verification organizations and accredits managed care organizations.

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COLORADO MEDICINE

July, 2000 **Volume 97, Number 7**



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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

A good deal of the focus and information at our CMS President Elect's Leadership Conference in Vail was on medical professionalism. Matthew Wynia, M.D. from the AMA's Department of Ethics discussed professionalism at length. I'm certain he won't mind my beginning this with some of the information presented at that conference.

I believe in recent years a great deal of the problems that have befallen individual physicians and medicine, as a whole, have resulted from a diminished focus on medical professionalism. We wish to maintain our status as professionals and avoid being pushed to the position of trades people; but in my opinion, individual physicians and physicians as a group have not done the work nor expended the effort necessary to continue that status.

Let me explain. Professionalism is a complex concept that has evolved through the centuries to involve an interaction between society (government), public enterprise (business), and those who would be professionals. This is best illustrated by a triangle systemizing this relationship and in order for a system to function well, this triangle must be balanced. We have allowed the triangle to become unbalanced toward government and business and away from our patients and our professionalism with which we represent them.

In today's medical economic environment, physicians increasingly encounter perverse financial incentives, fierce market competition, and circumstances that work to erode patients' trust. How bad can it get? At this week's AMA annual meeting I heard extensive testimony about the alarming use of peer review mechanisms in hospitals for competitive physician exclusion. Very credible and competent physician witnesses outlined how in a number of metropolitan areas across our country, legally protected peer review committees are being used perversely by groups of physicians to exclude their competition from hospital staffs and thence from provider panels. This is being accomplished under the guise of preservation of quality of care, and has used single cases involving complications to destroy the practices and/or exclude from practice very competent physicians. This is economic credentialing at its worst. How much more unprofessional can we be?

Professionalism is a trust endowed by society and serves society as a stabilizing force protecting vulnerable persons and vulnerable social values in that society. This social role of professionalism is not unique to medicine but has helped make medicine a unique societal system in its relationship with those it serves. Without professionalism, medicine is just another service provided by just another trade. That is why most consider professionalism to be an essential element of American medicine if we are to preserve our relationship with our patients. I believe that is why today's intrusion of business into medicine with its attendant loss of professionalism, is such a problem for physicians and their patients.

". . .this is the trust society places in our hands as physicians."

I also believe the only effective vehicle by which we can retain, nor even revive, medical professionalism is through and by involvement with our professional societies. Dr. Wynia helps me make that case in his articles in " Sounding Board", New England Journal of Medicine of November 18, 1999 and April 27, 2000. These are excellent articles and worth your reading time. He outlines three core elements of professionalism:

1. A moral commitment to the ethics of medical service.
2. A public profession of that ethic.
3. Engagement in a political process of negotiation regarding the ethic and its effect on the relationship between professionals and society.

Moral commitment to the ethic seemed easier early in our careers.

(Continued)

We have all perceived erosion of this commitment as systems of business have been imposed upon us resulting in the sort of intra-professional sordid tale related above. Recommitment is essential if we are to regain the collegiality so valued by our profession allowing us to support each other in this most difficult and complex of tasks (caring for our patients). We can achieve this standard of ethics only by placing the goals of individual patient and public health ahead of our own; this is the trust society places in our hands as physicians.

Public profession of values and political negotiation regarding those values are the two elements of professionalism physicians have badly neglected in the last many decades. By their recently increasing avoidance of their organized professional societies, physicians are neglecting this aspect of professionalism and public trust even more. It is in these societies and associations we can best advocate our patients' health care values rather than government or corporate values. This is how we physicians can rebalance that equilateral triangle mentioned above. The imbalance toward business and government is what has us and our patients so upset with our current health care system.

Join us at CMS and in the AMA as we work to repair physician collegiality (working together and helping each other) and restore medical professionalism. Without these our future is bleak but with them we can do much. We need your dues, but much more important, we need your commitment and your contribution of time and effort. Plato said it very well many years ago and it's still true: "The punishment of wise men who refuse to participate in the affairs of government is to live under the rule of unwise men."

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by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Recent Cases of Interest

By Robert Spencer
Shareholder
Montgomery Little & McGrew, P.C.

Two recent opinions handed down by the Colorado and California courts are of interest to all physicians. First, the good news:

Potvin v. Metropolitan Life Ins. Co.[1]

In 1992, Dr. Potvin, an Ob/Gyn of some 35 years experience, was terminated without cause from the MetLife provider panel. Because the termination deprived Dr. Potvin of most of his patient base, he sued. The trial court granted MetLife's motion for summary judgment, relying upon the termination without cause provision in Dr. Potvin's provider contract. Dr. Potvin appealed. Readers may recall that in 1997 the California Court of Appeals, in one of the first decisions of its kind, reversed the trial court, holding that the termination without cause provision was not consistent with public policy, and thus void. On May 8, 2000, the California Supreme Court upheld the court of appeals decision. The California Supreme Court's decision provide additional hope that the onerous termination without cause provision can be successfully challenged elsewhere.[2]

In affirming the lower court's decision, the California Supreme Court held that certain private institutions must be recognized as "quasi-public" when they provide important products or services, make representations to the public regarding their services, and exercise superior bargaining power over those with whom they deal. In such cases it is appropriate, in the public interest, to impose certain limitations upon the exercise of the organizations' contractual powers. This is true, the court held, in the managed care setting where MCO's exercise substantial market power, and the exercise of their contractual powers not only impact a physician's substantial economic interests, but also interfere with the interests of the patients whom they insure. Quoting from amici curiae briefs filed by the American Medical Association and the California Medical Association, the court noted that "the managed care organizations operating in California hold substantial economic power over physicians and their patients" and that " the control exercised by managed care organizations makes access to provider panels a 'practical prerequisite' to any effective practice as a health care provider." The court therefore found that because of these market powers and the public interests involved, MetLife's exercise of its termination without cause power could be appropriately limited.

Although the court found MetLife's termination without cause provision unenforceable, it did not suggest that MetLife, or any other MCO, was powerless to terminate providers for legitimate business reasons. The court specifically recognized that MCO's may have legitimate business reasons for reducing the size of their provider panel. MCO's, therefore, remain free to terminate providers without cause, provided that the removal is "both substantively rational and procedurally fair." Only terminations which are found to be arbitrary or in bad faith will not be upheld. In order to test the reasonableness of the MCO's decision, however, providers must be given adequate

(continued on next page)

notice of the reason for the termination, and an adequate opportunity for a hearing to contest the decision.

The Potvin decision also recognized that not every managed care organization wields sufficient market power to be considered a "quasi-public" organization subject to restriction. Rather, the obligation to offer a reason and hearing for termination without cause arises only when the MCO possesses power so substantial that the removal significantly impairs the ability of the ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area.

Although Potvin is now the law in California, it has no binding effect in Colorado or any state other than California. Nevertheless, the rationale of Potvin may be influential to other courts as they consider similar challenges to termination without cause provisions. A similar challenge is pending in Colorado. In Grossman v. Columbine Medical Group et al.,[3] the trial court upheld CMG's termination without cause of Dr. Grossman's provider contract, finding that there was no basis in Colorado law to void the express terms of the contract. Although the Colorado Court of Appeals upheld the trial court decision, a strong dissenting opinion adopted the public policy arguments which favor restriction of these clauses. Dr. Grossman has now petitioned the Colorado Supreme Court for review of the decision, and has cited the recent Potvin decision in support. The Supreme Court's decision whether or not to grant certiorari is pending. If certiorari is granted, the Colorado Medical Society has agreed to join in Dr. Grossman's appeal as an amicus curiae.

Rodriguez v. Healthone[4]

The Colorado Court of Appeals recently issued a decision expanding physicians' liability to non-patients in circumstances where the physician's conduct created an unreasonable but foreseeable risk of injury.

Mr. Rodriguez suffered RSD in his arm, for which he had been receiving nerve block therapy. Unfortunately, his treating anesthesiologist inadvertently injected his arm with intravenous phenol rather than the intended guanethidine. The partially used vial of phenol, had allegedly been left on the nerve block cart by another anesthesiologist, in violation of the hospital's policy to dispose of leftover phenol. Because the phenol was in a vial identical to the guanethidine vial, the treating anesthesiologist picked up the wrong vial and injected the phenol by mistake. A fasciotomy was performed to save the arm but several days later, during a dressing change procedure, the treating anesthesiologist compounded his error by administering too many sedatives to Mr. Rodriguez, resulting in cardiopulmonary arrest and severe anoxic brain damage. The treating anesthesiologist, understandably, settled out of court and the case proceeded against the hospital and the first anesthesiologist who had left the phenol vial on the nerve block cart.

The first anesthesiologist was initially dismissed from the case as he had no doctor-patient relationship to Mr. Rodriguez, and therefore was found to have no legal duty to him. On appeal, the Court of Appeals reversed this dismissal. It held that although the duty of care normally arises out of the professional relationship between physician and patient, a doctor-patient relationship is not essential to create a duty of care. The duty may also arise if the physician's conduct creates a foreseeable risk of injury to a non-patient. In this case, the court held that if the first anesthesiologist left the phenol vial lying around despite the hospital's policy to dispose of left over phenol, he created a foreseeable risk that the vial might be mistakenly used by another physician.

In one regard, this holding is not surprising. We all owe a duty not to create unreasonable and foreseeable risk of injury to others; just as the motorist owes a duty of care to the pedestrian in the crosswalk. The duty of care in the professional context, however, raises some special and interesting questions. For example, if a third anesthesiologist had seen the vial of phenol on the anesthesia cart, but took no action to dispose of it or warn of its presence, should that anesthesiologist also be liable for injury to someone not his patient? If a surgeon is aware that a peer lacks the competence to perform a surgical procedure safely, is that physician obligated to intervene upon pain of being held liable if the patient is foreseeably injured as the result of the peer's negligence? The court's decision does not hold or even suggest that a duty would be found in these situations, but once a physician's duty of care extends to patients beyond his own, it is difficult to detect a bright line as to where the duty ends. For now, practitioners should appreciate the possibility that it may, in certain circumstances, extend beyond their own patients.

REFERENCES:

1 California Supreme Court, SO61945, May 8, 2000.

2 The New Hampshire Supreme Court has also restricted the exercise of termination without cause clauses in provider contracts.Harper v. Healthsource New Hampshire, Inc., 674 A.2d 962 (N.H. 1996).

3 Colorado Court of Appeals, No.98CA0688, November 12, 1999.

4 Colorado Court of Appeals, No 98CA2173, May 25, 2000.

CMS Med Fax

OIG issues draft Compliance Program Guidance for Physician Practices

The Department of Health and Human Services Office of Inspector General issued draft guidance to help physicians in solo or small practices conduct effective voluntary compliance measures to prevent fraud and abuse in government health programs. The draft guidelines were published in June 12, 2000 Federal Register (pages 36818 through 36836). There is a 45-day comment period for the physician community to review the information and submit concerns and comments to the Office of the Inspector General. Comments can be submitted individually or routed through CMS. You can also obtain a copy of the draft compliance guidelines on the OIG website at www.hhs.gov/oig/new.html. You can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (720) 859-1001 or 1-800-654-5653, ext. 6328 if you have any questions.

Vasquez Boulevard/Interstate 70 (VB/I-70) Superfund Site

The United States Environmental Protection Agency (EPA) is currently evaluating residential properties in several Northeast Denver neighborhoods for arsenic and lead contamination in soil. Neighborhoods include parts of Elyria, Cole, Clayton, Southwest Globeville, and Swansea. The area, delineated by the Burlington Northern rail tracks to the west, Colorado Boulevard on the east, 52nd Avenue to the north and Martin Luther King Boulevard to the south, is referred to as the Vasquez Boulevard/Interstate 70 (VB/I-70) Superfund site.

Health agencies, including the Agency for Toxic Substances and Disease Registry (ATSDR) and the Colorado Department of Public Health and Environment (CDPHE), are investigating these neighborhoods to determine if the elevated levels of arsenic and lead found at some residential properties could cause health problems in the community. In July 2000, ATSDR will be conducting an exposure investigation at properties with the highest levels of soil contamination. Residents at these properties can be voluntarily tested for arsenic in urine and hair. In addition, the EPA has also offered blood lead and urine and hair arsenic testing to individuals residing at properties that have required soil removal due to high soil contamination levels.

If you would like more information about soil sampling or health investigations in these neighborhoods, any of the following people may be contacted:

Jane Mitchell
Colorado Department of Public Health and Environment
303-692-2644

Dr. David Mellard
Agency for Toxic Substances and Disease Registry
1-888-42-ATSDR

Gene Hook
Denver Department of Environmental Health
303-285-4068

Send us your calendar items.
If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Lawsuit Stress Support Seminars
July 6, 2000
Grand Junction, Colorado
Contact: (970) 243-2808

Internal Medicine Program
July 9-14, 2000
YMCA of the Rockies/Estes Park Center
Estes Park, Colorado
Contact: (303) 372-9065

Risky Practices- An HR Workshop
July 13, 2000
Parkview Hospital
Pueblo, Colorado
Contact: (720) 858-6178 or mtreber@copic.com

Risky Practices- An HR Workshop
July 20, 2000
Sterling Regional Medical Center
Sterling, Colorado
Contact: (720) 858-6178 or mtreber@copic.com

Colorado Academy of Family Physicians Annual Scientific Meeting
July 20-22, 2000
Sheraton Steamboat Resort
Steamboat Springs, Colorado
Contact: (303) 696-6655 or *E-Mail: cafp@iex.net*

"Women Physicians: Finding a Balance"
July 20-23, 2000
Iron Horse Resort at Winter Park
Winter Park, Colorado
Contact: (303) 470-3441

Renal Disease and Electrolyte Disorders
July 24-28, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

26th Annual Psychiatry Conference
August 2-4, 2000
The Given Institute
Aspen, Colorado
Contact: (303) 372-9065

Neurology Update
August 4-6, 2000
Aspen, Colorado
Contact: (800) 882-9153 or
www.uchsc.edu/sm/conmdedu/cmecal.htm

How To Practice Evidence-Based Health Care
August 6-10, 2000
Sonnenalp Resort
Vail, Colorado
Contact: sharlyn.walling@uchsc.edu or call (303) 315-7606

Lawsuit Stress Support Seminars
August 8, 2000
Fort Collins, Colorado
Location to be determined
Contact: Pat Schultz (720) 858-6055

Risky Practices- An HR Workshop
August 8, 2000
Denver, Colorado
Copic Insurance Company
Contact: (720) 858-6178 or mtreber@copic.com

Risky Practices- An HR Workshop
August 17, 2000
Fort Collins, CO
Cottonwood Club
Contact: (720) 858-6178 or mtreber@copic.com

Risky Practices- An HR Workshop
August 23, 2000
Grand Junction, Colorado
St. Mary's Hospital
Contact: (720) 858-6178 or mtreber@copic.com

Lawsuit Stress Support Seminars
August 29, 2000
Denver, Colorado
Copic Insurance Company
Contact: Pat Schultz (720) 858-6055

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Update on Infectious Diseases in Primary Care
September 16, 2000
The Antler Adam's Mark
Colorado Springs, Colorado
Contact: (303) 372-9065

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

The Palliative Care Certification Course
October 1-6, 2000
Westin Crowne Center
Kansas City, Kansas
Contact: (316) 263-6380

20th Annual Big Sky Pulmonary & Critical Care Medicine Conference
March 21-24, 2001
Big Sky Ski Resort
Big Sky, Monatana
Contact: (406) 442-6556

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

At Home and Away

At Home

2000 marks the 21st anniversary of the 9Health Fair. Ann Cosby, the Executive Director, reports that there was a statewide increase of 12% in participation. This year saw 68,788 individuals take advantage of the screening, 58,009 of whom had blood chemistry analysis test. The nursing staff of 9Health Fair reported making over 1,100 critical or alert calls this year. During July, 9Health Fair will be mailing approximately 68,000 reminder postcards, encouraging these individuals to visit their primary care physician or health care professional. This is to ensure that the person knows they may have screening results outside the normal range.

In 2000, 9Health Fair operated 137 screening sites, logging (as they say) "154 site days", at 63 Metro Denver sites and 74 sites statewide.

This year, the fair distributed over 25,000 colorectal "home kits" and provided mammograms, biopsies, ultrasounds and a continuum of care to men and women who qualified. This was made possible by a grant from the Susan G. Komen Foundation. Also, the Fair staff will be sending out a special mailing to all participants who had elevated ALT levels. There is a follow-up program in place with Schering Oncology Biotech and Hep C Connection for ongoing information access, a hepatitis help line and a free Home Access Hepatitis C Antibody Test Kit.

Why do I sound like a 9Health Fair public relations agent? Because they gave me the facts and figures, and I am merely repeating them for you, the physician.

What I can say on my own is that after 20 years it would seem that the 9Health Fair and Colorado Medical Society have developed a workable collaboration. Many of the first 20 years were marked with distrust and concern on the part of the physicians, and a state of wonderment by 9Health Fair staff. It wasn't until 7 or 8 years ago that the CMS House of Delegates voted to endorse the Fair and become an active, public participant. Since that time, the doctors who have served on the Advisory Boards and Councils of 9Health Fair have done an excellent job in helping 9Health Fair make the public more aware and responsible for their own health.

For all the questioning and distrust displayed by the docs in those first 12 years, there doesn't seem to have been many good reasons for that feeling; more and more doctors are finding that their patients are benefitting from the health fair; that they are not being unduly frightened by the screening results but that they are following up with their own doctors, making it a very positive process. More and more doctors are finding that new patients are being referred to them because of screening results, and this can't help but be a healthy situation.

Colorado Medical Society has never been a very aggressive *public* organization. Results of collaboations such as with the 9Health Fair can do a great deal for reassuring the public that the physicians are truly advocates of the patient, and that one of the primary reasons they participate in such public screnings is to assure the patient of the highest quality and most professional medical opinions and screening oversight.

Away

2000 also marks the year that Colorado Medical Society has delegates in three key positions in the AMA. Dr. Richert Quinn is a member of the Constitution & Bylaws Council and Chair of the Rocky Mountain States Council; Dr. Richard Allen was elected Chair of the Council on Medical Education, and; Dr. Joel Karlin has been elected Chair of the Council on Legislation.

In other matters, Randolph Smoak, Jr., was inaugurated as President of the AMA. Dr. Smoak, a surgeon from North Carolina, has already come out as a strong advocate for women as medical decision makers in health care. He has also declared that much of his effort in the coming year will be directed toward health system reform.



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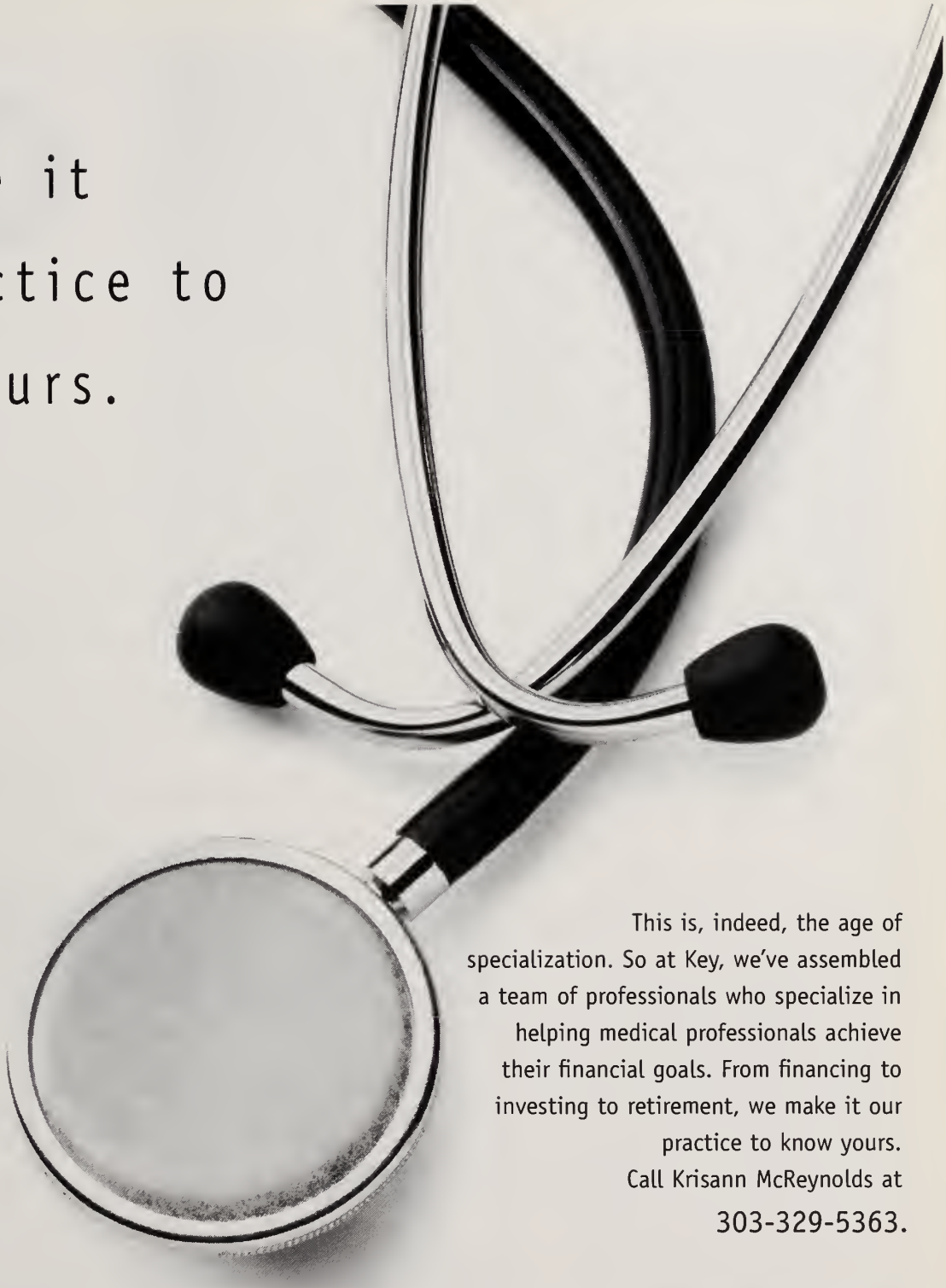
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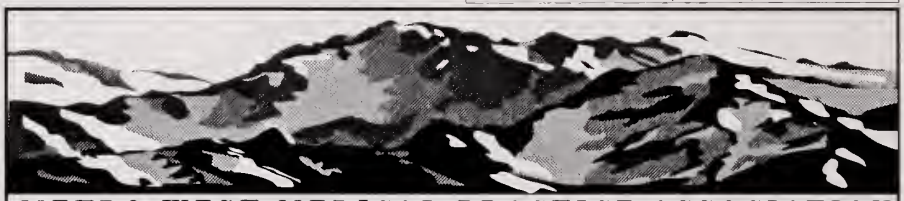
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2. Be recognized for outstanding community service, separate and apart form his/her medical service or activities.

We wish to honor the physician judged by his/her colleagues to have contributed most significantly to civic activities and the community good. All nominations must be accompanied by documentation of the physician's community services; i.e., testimonials from community leaders, honors and awards received by the nominee for outstanding community projects, testimonials from peers, friends and associates.

Address all nominations to:
Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550

Nominations must be received by Midnight, July 31, 2000, to be considered. The award will be presented at the CMS Annual Meeting in September, 2000, at the St. Regis Hotel in Aspen, CO.

Medical Marijuana: Bad Medicine, Bad Law

by Joel Karlin, MD and Jack Berry, MD



This November, voters in Colorado will be asked to approve a ballot initiative legalizing smoked marijuana for medicinal purposes. It has been couched as a compassionate care issue for people suffering "debilitating" medical conditions. But don't be fooled. It is the camel's nose under the tent for legalizing heretofore-illegal drugs in Colorado. It is one of the more significant public health threats to surface in Colorado in many years!

Colorado has been picked by a trio of very wealthy individuals with their own personal agenda as one of 7 states to face this initiative in November. They have "bankrolled" this initiative in several other states previously, including California and Arizona, and have been uniformly successful, in part, because of no organized opposition.

The initiative, Amendment 11, would amend the Colorado Constitution to make it lawful for a physician to provide a written note, not a prescription, to their patient certifying that the use of smoked marijuana might be helpful in treating a debilitating disease! That individual would then be permitted to grow 6 marijuana plants and carry up to 2 oz. of marijuana for their personal use. The amendment would create a state registry for such individuals, and protect them against actions by Colorado law enforcement officials for such actions.

Let's look at the arguments advanced by the proponents:

They will say that it will provide a needed medication not currently available to relieve pain and suffering in terminally ill patients. **But that's not true**. Marinol, the active ingredient in smoked marijuana, has been available by prescription from a physician since 1985.

They will say that the ballot process is the most democratic process to change state policy**. But it's not**. It bypasses representative democracy, designed to obtain all of the facts, and fairly debate the merits of any proposal. It bypasses the sentiments of your legislature and governor who recently passed a joint resolution opposing this initiative, and calling for state government to work with patients and their physicians to address any unmet needs.

They will say that it will not increase the number of people accessing marijuana and other illegal drugs. **But it will**. Surveys of high school students reveal that 60% never try marijuana. Most say that it is because the drug is illegal and they do not want to risk their future. More readily available marijuana will certainly increase such student utilization.

They will say that its use will not increase the use of other illegal drugs. **But it will**. Most heavy drug users first start with marijuana.

They will say that it will not impact the workplace. **But it will**. You will not know if fellow employees have smoked marijuana before coming to work. What effect this will have on their production, and how it may affect the safety of you and others? Will co-workers be taking breaks to smoke marijuana rather than cigarettes? Under the federal Americans with Disabilities statute, it will require employers to provide accommodation for these cardholders to smoke marijuana on the job.

They will say that it will not adversely affect driving or machinery operation. **But it will**. Recent studies have shown that people with a blood alcohol of .05% smoking marijuana are more drunk than people with more than twice that blood alcohol level alone.

Passage of this ballot initiative would create a precedent for the public to determine through ballot initiative which new agents would become available for use, bypassing the current FDA clinical trials. It would send the wrong message to our children. At a time that we are

(Continued)

Bad Medicine, Bad Law

(Continued from preceding page)

teaching them that marijuana and other "hard" drugs are wrong, passage of this amendment would confuse them by telling them that marijuana is "medicine".

Our Colorado Medical Society publicly opposed this amendment when it was first brought forth in 1998. The American Medical Association, the Governor, and the Colorado Legislature also oppose its passage.

Earlier this year, two Colorado physicians and members of the Colorado Medical Society, Dr. Frank Sargent, a Denver urologist, and Dr. Joel Karlin, a CMS past president, helped to form a citizen group to oppose this initiative. Coloradans Against Legalizing Marijuana **(CALM)** includes physicians, educators, law enforcement officials, clergy, state legislators, and concerned citizens. They have been meeting regularly to develop a potentially winning campaign. **They want Colorado to be the first state in the country to defeat this proposition.** That will only happen with the support of physicians and others who will help get the word out about this bad public policy.

We physicians can help in two ways:

1. Get the word out to your friends and patients. Display brochures to be provided to you in your waiting room; and
2. Contribute money to CALM that will permit them to get the message out to the public. The opposition has pledged major dollars to fool the voters in Colorado.

Mail your donation today to Coloradans Against Legalizing Marijuana, Michael J. Norton, Treasurer, 5445 DTC Parkway, Suite 850, Englewood, CO 80111-3053.

If 1,000 physicians contributed $100 each, we could raise a significant part of the budget required to defeat this amendment.

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Richard D. Krugman, MD, Dean
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100 Community Outreach Tours, and Counting

". . .if you have 'Colorado' in your name, it means the state . . ."

Recently, I made a whirlwind swing around the state, visiting 15 Colorado communities in three and one-half days. I was joined by Dennis Brimhall, President of University of Colorado Hospital; Patricia Hinton Walker, the Dean of the CU School of Nursing, and Marie Miller, the Executive Director of the Colorado Area Health Education Center System.

The main purpose for the tour was to recognize and honor outstanding community health care leaders, providers and organizations for their commitment to health care education and service. During the course of the trip, I had the privilege of thanking and honoring many local physicians, physician assistants and physical therapists for their dedication and voluntary service in providing clinical training experiences for School of Medicine students and residents.

These community health care providers play an important role in the clinical education and training of the students. For most preceptors, the opportunity to teach, to interact with the students and to benefit from the knowledge they bring with them is reward enough. For the students, it is a chance to gain first-hand clinical experiences from a health care professional.

The trip also served to mark the 100th community outreach trip by a team of senior administrators from the CU-Health Sciences Center and University of Colorado Hospital. Beginning back in September, 1992, our group went to every hospital and nearly county health department and nursing service, community health center and clinic in Colorado - many of them several times. In all, some 93 communities and over 180 health care sites were visited during that period.

The primary objective of those visits has been to gain a better understanding of the public health care issues and services in local communities in order to more effectively respond to the health care needs of local facilities, providers and patients. A second purpose has been to create educational support systems for local health care providers and clinical training experiences in community settings for CU health professions students.

Traveling around the state, as I have for the past 23 years (beginning as the first director of the Colorado AHEC System), not only has enabled me to stay in touch with physicians and other members of the health care system, but to better adapt educational programs and services to ever-changing needs of the providers in the communities they serve.

The recent "Centennial Tour" provided me with an appropriate opportunity to pause and recognize the many outstanding individuals who are having a positive impact on the clinical education and training of our students - the future physicians, physician assistants and physical therapists.

I don't plan to stop at 100, however, and look forward to future trips around Colorado for dialogue with and feedback from the medical community. I would welcome invitations from any of our Colorado Medical Society component county medical societies. As I often have commented, if you have "Colorado" in your name, it means the state and not Denver's boulevard.

NOTE: *If you would like Dean Krugman to visit your component society, please contact him at (303) 315- 7563.*



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John L. Lightburn, MD
Historian
Colorado Medical Society

The Wounds Are Healed

"AMA SEEKS CURE" was the headline in the June 11, 2000 issue of the Denver Post.

The article under the headline described how doctors expenses exceeding revenue by $9,200,000. The lack of interest in organized medicine by so many physicians is troubling. What does history tell us about the impact of organized medicine. What can we say about how our state's medical society had touched our professional lives? Fifty years ago, truly fine medical leaders devoted much of their professional lives to preserve the freedom for patients and physicians to enter into a relationship of their own choosing, a therapeutic alliance in which science and human understanding combined to provide comfort and cure from disease. In the following paragraphs, we continue our story of the leadership of the Colorado Medical Society.

Samuel P. Newman, MD was installed as our 84th president on September 24, 1954 at the Broadmoor Hotel in Colorado Springs. He had come to Denver after graduating from the University of Texas at Galveston, and by age 30 was acknowledged to be a brilliant orthopedic surgeon. Successful practice was not enough for young Sam; he plunged into the work of the CMS and soon became known for his leadership, judgment and hard work. Following two years with the Marines in World War II, he returned to Denver to resume his practice and to again become involved with the work of the CMS. His effectiveness and somewhat authoritarian manner resulted in his elevation to Chairman of the Board of Trustees (1941-1951). He supported his successor to the Chairmanship, McKinney Phelps, who had told incoming President William Liggett that the Chairman of the Board was in charge.

In 1952, Dr.



Samuel P. Newman, MD

Phelps and the Board created a special subcommittee to study the direction and structure of the society's committees, the Executive officers, and the activities of the office. The 20 page report of the subcommittee created considerable turmoil and the resignation of a twenty year staff member. Dr. Irvin Hendryson, who succeeded Dr. Phelps as Chairman, asked that "old wounds be healed and that we immediately put our house in order." The written record does not make it clear what had caused the conflict between good men each with the identical goal of supporting the medical profession.

Apparently Sam Newman was dissatisfied with the functioning of the society and in his presidential address, he presented the need for a strong organization to disseminate scientific knowledge, to enforce ethical conduct, to promote laws for public health and to defend the rights of physicians. His address had the tone of a general telling his troops what they had to do. During his presidency, he found his troops not entirely cooperative. Nevertheless, he made a significant contribution to organized medicine, serving eleven years on the AMA's Council on Scientific Assembly. He expected a lot of himself and of others.

Perhaps as a reaction to Dr. Newman's authoritarian leadership, the House of Delegates chose the next president to be a 'medical pacifist', Dr. Robert T. Porter, a Greeley internist who had received his MD and post graduate training in internal medicine and gastroenterology from the University of Chicago. He carefully avoided controversy, but yet two years after he joined with a group of physicians to form

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the Greeley Clinic, he found himself in the midst of a battle in which he and his colleagues were suspended from the medical society for alleged solicitation of patients! All was resolved a year later, and they were reinstated. In those days, groups were eyed with suspicion and envy.

Then in 1951, he found himself in more conflict when the House of Delegates elected him to a three year term on the Board of Trustees. This was the time when there was an angry schism, and contentious factions fought about everything. His presidency, however, was relatively peaceful. By this time, the bylaws had been changed so that the elected president was also the chairman of the Board. In his presidential address, he proposed a plan for CMS to build or buy a home office building it could call its own.

Under his prudent financial guidance, the society was able to acquire its 18th Avenue property.



Robert T. Porter, MD

Although Bob Porter brought peace and stability to the CMS, he was not truly a "pacifist'"; he spent two years in the South Pacific in the Army's 31st General Hospital where he became the personal friend of James Michener.

In 1946, George R. Buck became our 86th President. He received his MD from the University of Colorado in 1931. Money was scarce in the 30s and started out as a general practitioner with part time service as a Denver Police Surgeon to help pay the rent. Later he was able to take some post graduate study and eventually limited his practice to proctology. His World War II service in the U.S. Navy was a good experience for him and he returned to Denver a confirmed "Navy man". His activity in CMS started early, and he soon was Chair of the Public Policy Committee where he made some unpopular decisions, one of which was his support of voluntary health insurance. In 1940, he and John S. Bouslog and John W. Amesse were the original incorporators of the Colorado Medical Service (Blue Shield). Under his leadership, CMS and Blue Shield were closely allied for many years. I am sorry that alliance was not continued.

Dr. Buck became better known for his battle with the United Mine Workers over the denial of free



George R. Buck, MD

choice of physician to the beneficiaries of the U.M.W. welfare fund. This brought a suit by the unions against the CMS, a suit that the CMS eventually won. Not being satisfied with that accomplishment, he fought against the insurance companies who charged excessive rates for malpractice liability insurance. His response to these high premiums was to start the Empire Casualty Co., a physician owned firm and something of a predecessor to the present day Copic Insurance Company.

Our next President was Gatewood Milligan, an Englewood general practitioner. All omens were good when he assumed the Presidency in September, 1957. Here was a man with a wealth of organizational experience, a man approaching the zenith of his career, a leading general practitioner who held the respect of specialists, a student of socio-economics and medical public relations and a team leader that always made certain that the team got the credit. He was universally liked, and appeared to be in excellent health. But in December while attending an AMA conference in Philadelphia, he suffered an episode of hemoptysis. The tubercle bacillus was found and he was advised that he must spend several months in the hospital and have several more months of rest. So he resigned his presidency.

Since Gatewood is still alive and I wanted to learn more about the 50s, I talked to him on the phone and asked if I could interview him in



Gatewood Milligan, MD

his Englewood home. He and Maxine, his wife of 67 years live in a beautiful home situated on the brow of a hill overlooking the Platte valley with a panoramic view of the entire front range of the Rockies. Although 93 years old, his appearance and speech is that of a man twenty years younger. Here is a brief summary of his story:

Gatewood was born in Shannon, Mississippi on July 23, 1907. His father, M. Gatewood Milligan, was a Presbyterian minister who had pulmonary tuberculosis. The unconfirmed story is that the disease was first diagnosed three years before at an exhibit of Roentgen's marvelous new machine at the Saint Louis Fair in 1904. True story or not, he did have a tubercular infection and moved his family Colorado. After a year in a Colorado Springs sanatorium, he settled in Victor where he was the pastor of the Presbyterian church for five years. Raising a family in a mining camp was not to his liking so he moved his family to

(Continued)

Sterling where he became the pastor of the First Presbyterian Church. Gatewood finished school in Sterling and started college at Park College, a small Presbyterian school in Missouri. You know what they say about ministers' sons. Gatewood was caught smoking a cigarette and was expelled from this very strict church school. He continued his education at another church college in Hastings, Nebraska and finished his premedical studies at the University of Wyoming.

He was graduated from the University of Colorado School of Medicine in 1933. After finishing a year long internship in San Antonio, Texas, he began his general practice in an office on South Federal Boulevard. This was in 1934, the very depth of the Great Depression. Maxine's full time job helped pay the rent and buy the groceries. He had a real struggle and for a while moved to the coal mining town of Erie. With the improved economy, he was eventually able to move his practice to Englewood where he opened an office on south Broadway, a location he maintained until his retirement in 1984.

In those early days, medical students at the University of Colorado were required to attend fifteen deliveries as part of their obstetric course, ten hospital deliveries and five home deliveries. Gatewood found obstetrics one of his favorite parts of general practice. And home deliveries became an important part of his practice. His fee for home delivery was $25.00. This covered prenatal care. His practice prospered and he became well known and well loved in the community. He was recognized and respected in the CMS as a successful leader and was appointed by three different presidents as Chairman of the Public Policy Committee. The CMS presidency was the next logical step. The pulmonary tuberculosis that required his resignation from the Presidency was not his first brush with the disease. His father came to Colorado for the cure; in the 1918 influenza epidemic, his father suffered a recurrence of the disease. Gatewood's first evidence of tuberculosis was in 1940 when he underwent a nephrectomy for a tubercular kidney. Then came the lung infection in 1957. After the diagnosis was confirmed, he was admitted to the Swedish Sanatorium where he stayed for two months. The sanatorium had only six patients and was about ready to close. Shortly after his discharge, the sanatorium was closed. After two more months of rest at home, he slowly resumed his practice. He became one of the founding members of the medical staff of the new Swedish Hospital and was the staff president in 1959. From patient to president in less than three years! His work in the CMS continued as a delegate to the AMA and was chairman of the Colorado delegation in 1971.



Clare C. Wiley, MD

Clare C. Wiley from Longmont, elected vice-president served as president for the remaining nine months of Dr. Milligan's term. He was one of the youngest men to serve as CMS president. Something of a worrier, he worked at his new assignment very seriously and successfully. He had finished his medical education at the University of Nebraska in 1941. Immediately following his internship at the Long Island College Hospital he started active duty as a Lieutenant, U.S. Naval Reserve, becoming battalion surgeon for the 22nd Marines in the South Pacific. He began his medical practice in Longmont as a solo general practitioner and in 1947 he became a partner in the Longmont Clinic where he emphasized pediatrics. He was a hard worker who seldom took vacations.

John I. Zarit was our 89th President, 1958-59. He had a delightful sense of humor. He often referred to himself as "Father John" and calling his Catholic friend,



John I. Zarit, MD

"Rabbi Vance". Dr. Zarit received his MD degree from the University of Colorado in 1924, completed his internship in Brooklyn and his medical residency at Jewish Consumptive Relief Society (JCRS) in Jefferson County. His primary interest was tuberculosis and he chaired the CMS Subcommittee on Tuberculosis Control from 1946 to 1958. From 1953 to 58, he chaired the Public Health Committee itself, supervising 11 subcommittees. He personally gave annual dinners for his committees where he gently but firmly drove them until CMS was more active in Public Health than it ever had been. This was recognized in 1957 when the Colorado Public Health Association gave him the annual Sabin award.

His office was on the same floor as the CMS office in the Republic Building, and as president of CMS, he visited CMS daily, occasionally taking the names of members who were delinquent and calling them to remind them of their obligation.

So there you have the 50s. They were turbulent for the society, but we had good leaders and much was accomplished. They tried to anticipate the needs of the future, recognized the need for change and took an important step in effective cost control and volunteer health insurance.

Should we have been more cognizant of their wisdom?

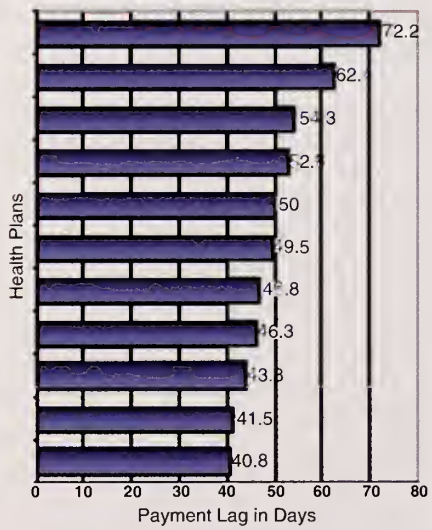
Slow Pay

by Marilyn Rissmiller, Program Manager
Division of Health Care Financing
Colorado Medical Society

Reprinted in full from the May/June issue of the ***CMS Office Manager*** newsletter.

Hassle Factor Project

- **Average Payment Delays by Top Colorado Plans**
- **High was 72.2 days Low was 40.8 days**
- **Overall average: 50.5 days (all plans/respondents)**



Slow insurance payments continue to be a major concern for many physicians and their staff, locally as well as nationally. The results of last year's CMS Timely Payment survey appear to validate these concerns. The survey results showed that at the high end, the average time it took to receive payment was 72.2 days, while the low end was an average of 40.8 days. The overall average of all insurance plans and all respondents was 50.5 days.

CMS shared the survey results with the representatives of the HMO Association at the April meeting of the Joint CMS/CHMOA Committee. We took this opportunity to present the survey information to the group as a first step toward a continuing dialogue regarding the overall issue of claims processing timeliness. Some of the plans wanted more information and asked to meet with us individually so they could get specifics on how their performance was viewed.

The timely payment law that took effect 1/1/2000 was discussed, and the HMO members were asked if they had made any provisions for monitoring and paying interest due. Two of them (PacifiCare and Rocky Mountain HMO) indicated that they were in the process of updating their computer systems to automatically track late payments and access the additional charges due for interest. We advised the HMO Association that we (through the CMS members) would be monitoring the effectiveness of the law, as well as compliance with payment of interest charges that are owed.

In our discussions with office staff the timely payment law continues to be a hot topic. Everyone still has lots of questions and "what ifs," but our advice remains the same:

1. **Know/follow each plans' "clean claim" requirements;**
2. **Know which claims are protected under the Colorado law;**
3. **Monitor those claims and when they are outside of the timeframes outlined in the statute, follow-up with the insurance plan;**
4. **Keep CMS advised regarding continuing late payments.**

We will be sending a follow up survey to all CMS members requesting updated information on claims processing timeliness. We will compare the new survey results with those from last year to determine what affect the timely payment law has had.. We encourage you and your staff to continue to participate in this important project.

Let us know if you have a specific question on the timely payment law and we will get you the answer. You can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (720) 859-1001 or 1-800-654-5653, ext. 6328.

CMS Office Manager

A newsletter to provide medical office staff with information on health insurance.

Highlights of the May/June 2000 issue

The CMS Office Manager newsletter is a bimonthly publication dedicated to providing your office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on CMS analysis of the problems facing the physicians' offices.

DOI Looks at "No Pay" The reoccurring problem of physician organization insolvency has prompted the Colorado Division of Insurance (DOI) to set up a task force to look at provider risk. William J. Kirven III, Commissioner of Insurance, spoke to the CMS Managed Care Task Force members regarding his perception of the problems and his goals to resolve them. He is convinced that there has been a breach of trust between insurers and physicians and that this has lead to a breakdown of the relationship. He believes this is one of the biggest contributors to the problems in Colorado's healthcare system.

Colorado State Legislation The 2000 Colorado state legislative session ended on May 3rd. A status of some of the bills the CMS Government Relations staff monitored for members during this session was outlined in the newsletter. A complete listing is available on the CMS Web page. Go to CMS Home Page (http://www.cms.org), select "CMS for Physicians" then select "Heard on the Hill" for the list of CMS legislative activity.

In other words, I want my claim paid. . . Whether the process is called a review, an appeal or a request for reconsideration, the bottom line is you want your claim paid. Each plan or insurance carrier has a slightly different procedure or terminology involving what we will generically refer to here as an *appeal*. To have your efforts "pay off" you will need to do your homework and be persistent. The full article contains helpful tips.

What about a compliance plan? This is a question we get asked a lot. An effective compliance plan can be a very good means of increasing the effectiveness of your inter-office communication. But, in order for the plan to succeed, there must be a commitment from everyone in the office not only for the implementation but also for the ongoing process. No matter how a compliance plan is developed, the basic elements of the plan remain the same. In this article by Joan Elfeld, independent consultant, she provided information on the seven elements and their purpose.

Sloans clarifies their claim filing instructions Sloans Lake is an organization that offers cost containment programs, including their PPO network, to third party payers of health care costs. In recent meetings with Sloans Lake staff we discussed the confusion that can arise when claims are sent to them but they keep no record in their system. (In fact, other than delay in payment, the majority of complaints we receive regarding Sloans are related to lost claims and claims filing problems.) In response to our discussions, Lauris Grabeklis, Assistant Vice President of Operations has asked us to publish a clarification.

In response to your question. . .

Question: When time is used as an overriding factor in selecting the level of E&M code, how is the documentation changed?

Response: If the doctor spends over 50% of the visit time face-to-face with the patient counseling him or her, time can be used in selecting the level of E&M code. . .

If you would like to see any article in its entirety, ask your office staff to share the latest copy of the "CMS Office Manager" with you. If your office is not already on the mailing list, there is an order form on page 234 in this issue of ***Colorado Medicine.***

Cookbook Medicine Verses Good Medicine

by W. William Schluter, M.D., MSPH and
Richard G. Kessel, Ph.D
Colorado Foundation for Medical Care

"...shorter patient visits—increasing expetations and demands."

"Standing orders are just one more means of interfering with physicians' ability to practice medicine." Sound familiar? In an age where demands on physicians are coming from everywhere, it can feel as if every bureaucrat and administrator is trying to make clinical decisions for you. "I know what is best for my patients," is the frequent argument against standing orders. When trying to juggle an increasing case load while covering inpatients, the last thing you want is an outsider telling you how to practice medicine. Considerable evidence, however, suggests that establishing your own standing orders may be exactly what you need to reduce some of the burden on yourself and bring back the joy of practicing medicine.

The reality of modern practice is that patient visits are getting shorter while expectations and demands are increasing. While every physician strives to provide the best care, sometimes the demands are overwhelming. Unfortunately, routine preventive care can get lost in the maze of multiple complaints, acute needs, and the management of chronic conditions. Rather than infringing upon a physician's ability to practice medicine, standing orders for routine care can allow physicians more time to focus on the complicated issues that require physician level decision-making.

Few physicians would argue against vaccinations. Despite recent controversies in the media, the practice of vaccinating children is so routine that entire office systems are built around vaccination schedules. Adult vaccinations deserve equal consideration. Only 74% of Colorado's Medicare population, those at highest risk for complications, have received their flu shot while 20,000 deaths each year are attributed to influenza nationally. Pneumococcal disease is responsible for more deaths than any other vaccine-preventable bacterial disease yet only 53% of Colorado's Medicare population have received vaccination.

Why is commitment to vaccinations so high yet the rate of vaccination so low? The answer was alluded to above; the multiple burdens placed on physicians. Even a highly learned individual is only able to process six, +/- two, pieces of information at one time. Medicare-aged patients are more likely to have multiple, chronic health issues. Managing these patients fully utilizes the physician's skills and capacity. It should be no surprise then that vaccination rates are highest when physicians have removed themselves from the process and issued standing orders to screen all patients for appropriate vaccinations and to provide those which have not been given.

Standing orders for adult vaccinations are so important that the Advisory Committee on Immunization Practices has recently published recommendations stating that all clinical service facilities should develop standing orders protocols. All facilities, inpatient and outpatient, long-term care and urgent care, should have personnel trained to screen patients for contraindications, administer vaccines, and monitor patients for adverse events without direct physician involvement.

Visit the CFMC Web Page
and see the many services
offered to help
you and your patients.

Colorado Foundation
for
Medical Care
at
www.cfmc.org







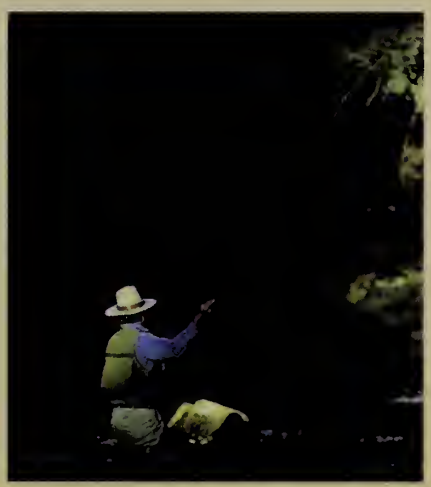
CMS Annual Meeting

September 22-24, 2000

St. Regis Hotel

Aspen







From the

COLORADO MEDICAL SOCIETY

A MEMBER BENEFIT SERVICE SINCE 1989

- THIS SERVICE IS NOT AVAILABLE TO THE PUBLIC -

Professional assistance for CMS doctors planning to buy or lease a new vehicle...



" Since it began in 1989, several hundred CMS members have used this service at least once. Many have used it several times. Virtually all report substantial savings in time, money, and hassle, and often recommend this service to other CMS members. "

Sandra L. Maloney, Executive Director
Colorado Medical Society

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Call *(303) 753-0440* in Denver

Or go to *www.cms.org*, select **For Physicians**, look in **Member Services.***

*** For 24 hr. immediate information, the CMS link to RMFA includes *WebCarbooks*, the highest rated vehicle price and option guide on the internet.**

- RMFA IS A LICENSED AND BONDED DEALER -



COLORADO MEDICAL SOCIETY
YEAR 2000 FINANCIAL WORKSHOP

"SO YOU WANT TO BUY OR SELL YOUR PRACTICE?"
PEARLS AND PITFALLS
A CASE STUDY



I. 2:00 - 2:15PM - Year 2000 Mission - Physician Services
Richard R. Ellis, Jr. - Executive Vice President
Copic Financial Service Group

II. 2:15 - 3:00PM - Tasks Necessary to Buy or Sell a Practice
Leon B. Harrison CLU - Copic Financial Service Group

- The Current Medical Practice Environment
- Equity Purchase - What Will it Cost - How do I Pay for It?
- Separating Professional Goodwill From Practice Goodwill
- Goodwill Requires Enforceable Covenant Not To Compete
- Financial Projections/Proforma Reports/Feasibility Studies - For Line of Credit/Equipment Acquisition and Working Capital Financing

III. 3:00 - 3:30PM -How to Fund Your Equity Buy/in - Buy/out
Mike Edwards CFP Copic Financial Service Group

- What is Being Bought/Sold - Assets or Stock?
- Buy/Sell Agreements - What will it Guarantee?
- How Practices Phase Out Their Older Doctors
- Deferred Compensation - A Way to Receive Goodwill?

IV. 3:30 - 3:45PM - Break

V. 3:45 - 4:30PM - Tax Traps to Avoid
Leon B. Harrison CLU - Copic Financial Service Group

- Physician Employment Agreement Income Distribution
- Section 1060 (e) Issues - *LOOKOUT!*
- Stark I-II/Fraud and Abuse Landmines
- What to do When Negotiations Begin to Show Promise

VI. 4:30 - 5:00PM Open Question/ Answer Workshop

Advocating Excellence in the Profession of Medicine

Colorado Medical Society Annual Meeting Educational Program

Who: This activity is designed to address needs and interests of Colorado physicians from all specialties. Others who have interest, are welcome to attend (e.g., ancillary staff, medical executives of component societies, and other guests and attendees of the CMS Annual Meeting).

What: What we want to accomplish, and how we will know it is accomplished:
1) Demonstrate, overall, that although there may be disagreements among physician groups on various issues, the delivery of high quality care is and will remain an unwavering area of common professionalism amongst physicians.
2) Each segment will have specific objectives based on the area of quality chosen (in progress). The audience will be asked to evaluate achievement of those objectives. Each presenter will be asked to integrate ethical considerations, future CME needs and how the use of technology (when applicable) is facilitating the work.
3) This will be a continuation of a theme set by CMS President-elect Dr. Richard Allen for his presidential term: Rediscovery and re-definition of medical professionalism through discussion and provision of information on ethics, the science of medicine and education.

Dr. Matthew Wynia from the Institute of Ethics will begin the program with a continuation of the medical professionalism topic (45 minutes);

Emphasis will be placed on quality improvement and control programs now in use in a variety of applications.

Representatives from the Colorado State Board of Medical Examiners, Colorado Foundation for Medical Care, Copic Companies, Colorado Medical Society, and University of Colorado School of Medicine will each present their quality project in a 30 minute timeframe, followed by a 15 minute question and answer period. Decision-makers from each of these organizations will be represented by qualified individual presenters.

Dr. Wynia will provide a 15-minute wrap up and evaluation segment to conclude the program.

When: Saturday, September 23, 2000. 7:30 A.M. to 12:45 P. M.

Where: Colorado Medical Society Annual Meeting 2000; St. Regis Hotel. Aspen, Colorado.

Why: The recent Institute of Medicine Report regarding "medical errors" was sensationalized in the public press by implying that medicine has been negligent in the delivery of care to patients. By looking deeper into the report, it is discovered that 99% of "errors" are the result of system failures, and not caused by individuals or an individual group (e.g., physicians). In Colorado, there are several major physician organizations, all of whom have one common, agreed-upon goal: the delivery of high quality medical care to the people of Colorado. We wish to provide an educational program that gives each of these groups a forum for presenting work being done by their organization in this important area. It will serve to publicly profess that physicians do not deny that errors occur, and, in fact, continuously work to improve the delivery of care to patients.

CME Hours: 5.0 AMA Category 1 credit.

Annual Meeting Registration

2000 Annual Meeting of the Colorado Medical Society
St. Regis Hotel • Aspen • September 22-24, 2000

Name (please print) _____

Component Society _____

Name of Spouse/Guest(s) _____ **CMS Alliance Member** ❑**Yes** ❑**No**

*If you are not a member of CMS, please provide the following information and **$125** for registration fees:*

Company/Organization _____ **Title** _____

Registration deadline is September 11, 2000. Registrations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. *(Note:* If you have not pre-registered for Saturday's dinner/dance, you must do so before noon on Friday, Sept. 22 at the Registration Desk.)

Complimentary Events for CMS Member & Spouse/Guest
Except for the COMPAC/Alliance Luncheon, you and one guest are entitled to attend all events at no charge. To confirm your reservation, use the boxes below for yourself and one guest and the shaded area for additional guests.

Thursday, September 21	member	spouse/guest
6:00 pm Welcome Reception	❑	❑

Friday, September 22		spouse/guest
8:00 am Alliance Breakfast		❑

Saturday, September 23 *(Complimentary for member & one guest **only**)*			**CHARGES FOR ADDITIONAL GUESTS**
7:00 am Breakfast Buffett	❑	❑	# _____ @ $25/each _____
8:00 am Education Program	❑	❑	
12:45 pm AMA Forum Luncheon	❑	❑	
7:00 pm President's Dinner Dance			
Meat dinner	❑	❑	# _____ @ $95/each _____
Vegetarian Dinner	❑	❑	# _____ @ $95/each _____
Vegan Dinner	❑	❑	# _____ @ $95/each _____

Other Events

Friday, September 22 * CHARGE PER PERSON FOR **ALL** MEMBERS AND GUESTS

12:30 pm COMPAC/Alliance Luncheon #_____@ $35/each*_____ COMPAC Member
#_____@ $45/each*_____ Non-COMPAC Member

Please make check payable to: **Colorado Medical Society** and mail this form.
TOTAL amount enclosed for non-members, additional guests and COMPAC Luncheon. $ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 720-859-1001 or 1-800-654-5653); or fax it to us (at 720-858-7509).

Hotel Reservation deadline is 8/13/00.

Hotel Registration

The St. Regis Aspen Room Reservation Request Form

Colorado Medical Society Annual Meeting - September 22-24, 2000

It took peaks as high as the Rockies to match the height of service The St. Regis Aspen aspires to. It took the premier resort of Aspen to set the standard for a vacation experience. It took the traditional elegance of The St. Regis Aspen's mountainside accommodations to bring all this together under one roof of luxurious appointments.

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The St. Regis ASPEN

Please print or type the following and mail or fax form with deposit payment to The St. Regis Aspen:
315 East Dean Street, Aspen, CO 81611
970-920-3300 Phone
970-920-7353 Fax

Name_____

Address_____City_____State_____ Zip Code_____

Phone number_____ Number of guests_____

Fax number_____ E-mail address_____

Arrival date_____ at_____ AM/PM (Check in time is after 3:00 PM)

Departure date_____ at_____ AM/PM (Check out time is 12 noon)

$175 single/double occupancy

Rates are per room per night and do not include the room tax, currently 8.2%.

❑ king bed ❑ 2 double beds ❑ smoking ❑ non-smoking

Method of payment

❑ Check enclosed ❑ American Express ❑ MasterCard ❑ Visa ❑ Diner's Club ❑ Carte Blanche

Account #_____ Exp. date_____

Signature of card holder_____

Deposit and cancellation policy: A deposit equal to 100% of total nights booked is required in order to confirm your reservation. This deposit is due 30 days prior to your arrival. Should The St. Regis Aspen not receive the deposit, the reservation will be cancelled. Your deposit is refundable if reservations are cancelled more than 30 days prior to arrival. All deposit money is non-refundable if a cancellation is made within 30 days of the arrival date, or if you check out earlier than your scheduled departure date.

Reservation cut-off: Rooms will be held for the attendees of the Colorado Medical Society Annual Meeting at the special rate for the nights of September 20-24, 2000, until August 13. Reservations received after August 13, 2000, or for days other than 20-24, 2000, will be accepted on a space available and charged at the prevailing hotel rates.

Use of the Fitness Center will be billed at $6 per visit.

Overnight valet parking will be billed at $17 per night, reduced from $19/night for CMS guests.

Special requests:

Please check that you have completed all pertinent information. Reservations should be made **before** August 13, 2000, to assure accommodation availability.



TEE UP!

Entry Form

CMS Annual Meeting Golf Tournament
Aspen Golf Course
Thursday, September 21, 2000



Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____

Home Phone _____ Fax Number _____

E-mail Address _____

While in Aspen I will be staying at _____

My golf handicap is _____ or My average score is _____

I prefer to be teamed with _____

If you would like to play, please return this entry form as soon as possible because space is limited.



Tournament tee times are reserved starting at 8:08 am. Foursomes to choose their own type of play (scramble, individual, etc.). Prizes to be awarded for individual contests (long drives, closest to the pin, etc.) Foursomes will be arranged; please specify if you have a preference of partners. To ensure tournament registration, please send entry form and advance payment of $130 by September 1, 2000 to:

Barbara Campbell, 2251 Ash Street, Denver, CO 80207. For more information please call Barbara at 303-388-5307 or email to BarbLRA@aol.com.

Annual Meeting Schedule

The St. Regis Hotel-Aspen • September 22-24, 2000

Thursday, September 21st

8:00 am	CMS Office open
8:00 am	18-hole Golf Tournament - Aspen Golf Course
1:00 pm-2:00 pm	Finance Committee
2:00 pm-5:00 pm	Board of Directors
4:30 pm-7:00 pm	Registration open
6:00 pm-7:30 pm	Welcome Reception Dinner on your own

Friday, September 22nd

7:00 am	CMS Office opens
7:00 am-4:00 pm	Registration
7:00 am-7:45 am	Reference Committee Breakfast
7:00 am-7:45 am	New Delegate Orientation
7:00 am-7:45 am	Rural Physicians Forum
7:00 am-8:00 am	COMPAC Board
7:45 am-8:00 am	Credentials Committee
8:00 am-8:30 am	Opening Session - House of Delegates
8:00 am-9:30 am	CMS Alliance Breakfast
8:30 am-12:15 pm	General Membership Meeting
9:30 am-12:00 N	CMS Alliance Membership Meeting
12:20 pm-1:45 pm	COMPAC/CMS Alliance Luncheon
2:00 pm-3:00 pm	Copic Risk Management (E.M.R.)
2:00 pm-3:00 pm	Copic Risk Management (Radiology)
2:15 pm-4:30 pm	Reference Committee
3:15 pm-4:15 pm	Copic Risk Management (Surg. Sub. Specialties)
3:15 pm-5:15 pm	Reference Committee
6:30 pm-7:30 pm	Colorado Chapter, American College of Physicians/American Society of Internal Medicine (ACP/ASIM)
7:00 pm-9:30 pm	Gone But Not Forgotten Dinner (by invitation only)

Saturday, September 23rd

7:00 am	CMS Office opens
7:00 am-11:00 am	Registration
7:00 am-7:30 am	Breakfast
7:30 am-12:45 pm	Education Program
9:00 am-11:30 am	CMS Alliance Program
10:00 am-10:30 am	Break
12:50 pm-1:55 pm	AMA Forum Lunch
2:00 pm-5:00 pm	Copic Financial Seminar
5:30 pm-6:15 pm	Meet the Candidates Reception
6:15 pm-7:00 pm	Inaugural
7:00 pm-10:30 pm	Presidents' Dinner/Dance
8:30 pm-10:00 pm	Copic Dessert Reception

Sunday, September 24th

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 am-9:30 am	Registration
7:00 am-8:30 am	Component Caucuses (Arapahoe, Aurora-Adams, Boulder, Clear Creek Valley, Denver, El Paso, Larimer/Weld, Pueblo/Western Slope)
8:15 am-8:30 am	Credentials Committee
8:30 am-12:00 N	Closing Session House of Delegates
12:00 N or immediately following HOD	Reorganizational Board

Dine & Dance
to the music of
Colorado Power Company



at the
President's Dinner-Dance

Saturday Night, September 23rd: Reception from 5:30 - 6:15, Presidential inaugural 6:15 - 7:00. Dinner at 7:00.

The ***Colorado Power Company*** *is a 9-piece band that plays a variety of music from the Swing Era and Neo/Swing to Latin, Classic Rock, and some Country.*

The band includes the piano, upright and electric bass, drums, guitar, saxophone/flute/clarinet, 2 trumpets, trombone, and female vocalist. Five members of the band are also vocalists. ***Colorado Power Company*** *is from Carbondale, Colorado, and performs at many Aspen Valley functions. Directed by Bill Parish, the Colorado Power Company is a well-known and popular music group.*

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



"Sustaining Core Values in a Time of Change"

I recently attended the annual meeting of the Physician Insurers Association of America (PIAA). The PIAA is a national trade group for physician-directed insurance companies. Copic is a longtime member. The theme for this year's meeting was "Sustaining Core Values in a Time of Change." Several aspects of the meeting had particular resonance for Copic and those we insure.

Roger J. Dow, Senior Vice President of Marriott Corporation, gave the keynote address. His message, echoed by all of the meeting's speakers, was that that what you do (the core mission) and why you do it (the core purpose) must remain fixed over the life of an organization. Within these boundaries, however, organizations are free to (and, indeed, must) develop flexible goals, objectives, and strategies to respond to ever-changing micro and macro environments. Reviewing Marriott's evolution over the past 70 years, Mr. Dow attributed the company's enviable success to its ability to live up to its core mission and purpose while simultaneously implementing necessary changes and progress to improve and renew itself.

That got me thinking about Copic. Our core mission (what we do) is to "...provide for the needs of our customers (emphasis added), including a stable market for professional liability and other insurance products, principally in Colorado. This will be accomplished through sound management, financial strength, optimum service, risk management, educational activities, strong leadership, and advocacy." Our core purpose (why we do it) is "...to add value to the healthcare delivery system."

Over the years since our founding, we have pursued various value-driven strategies to accomplish our core mission. We began in 1982 by responding to Colorado's need for a stable, affordable source of medical liability insurance. When you told us in 1985 that you needed Copic-quality service for your business and personal insurance coverages, we created what is known today as Copic Financial Service Group. And in 1995, when it became obvious that the paperwork associated with credentialing was detracting from your core mission of providing quality patient care, Copic purchased Gadrian Corporation to begin to streamline this burdensome task. Similarly, when NCQA-mandated site visits and medical record reviews threatened to disrupt your practices, Copic drew on its risk management expertise and developed Practice Quality to handle this necessary task with minimum interruption and maximum sensitivity to the practice's workflow and procedures.

What strategies will Copic pursue in the future to accomplish its core mission of providing for your needs? Richard Krugman, M.D., Dean of the CU School of Medicine, also spoke at the PIAA meeting and gave us a preview of the physicians of the future: 50% will be female (only 22% of current Copic-insured physicians are female); they will begin their medical education later in life (typically beginning at age 30 instead of 22); and they will be highly computer and Internet literate (wanting to conduct much of their business over the Web). These characteristics will most certainly have an impact on Copic's strategies going forward. In addition, a recent needs-assessment survey sent to 3,000 of our current insureds at the end of May will allow those we serve to provide detailed information for Copic to use as we develop future goals, objectives, and strategies consistent with our mission and purpose. If you received this survey, I encourage you to complete it and return it as soon as possible.

No matter how we may be required to adapt our strategies, you can be certain that every move Copic makes will always be undertaken with an unswerving focus on you and your needs. Times may change, but Copic's core mission and purpose never will.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

Colorado Physician Network (CPN)

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The Colorado Physician Network Board of Directors welcomed four new members at its June 7, 2000 meeting. In attendance were Mary Jean Berg, Family Practitioner from Rocky Ford and Ordway, Larry Walls, Internist from Pueblo, Peter Monheit, Family Physician from Denver Metro, and Richard Allen, Denver OB/GYN and President Elect of Colorado Medical Society. Though new to the CPN leadership, all bring extensive experience in managed care activities and each contributed significantly to the complex and lively discussion.

CPN and Rocky Mountain HMO are energetically pursuing a strategic business plan designed to tighten and enhance the "partnership" between individual Primary Care Physicians and the organizational administration. As open enrollment in September promises substantial growth in membership, Primary Care Physicians will be allowed to choose their level of participation in RMPC practice growth proportionate to their commitment to our Core Values of effective management methods. Those who embrace the concepts may elect to grow their RMPC population, whereas those with limited involvement or interest may request a more passive role – pending establishment of PPO and self funded products that carry less financial risk. Details will be forthcoming as they are more precisely defined in the weeks ahead.

We are excited by the energy and wisdom of our 2000 Board of Director's, and the opportunity to provide innovative solutions to rising costs, declining profitability, and escalating disenchantment for our physicians, our organization and our patients alike. To our Primary Care Physician's in the Denver Metro and Colorado Springs regions, we expect to be in contact with you soon.

Colorado Medical Political Action Committee

P.O. Box 17550 • Denver, Colorado 80217-0550 • 720-859-1001

You're too busy practicing medicine to play politics.

Join COMPAC today and become personally involved in the future of health care in Colorado, **without playing politics.** Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (720) 859-1001, or 1 (800) 654-5653, extension 6327.

The Alliance



Joyce Wilson, President
Colorado Medical Society Alliance

Membership continues to be a challenge for the CMS Alliance. The challenge was met in part this past (1999-2000) year as we received an AMA Alliance award for a 5% increase in AMA Alliance membership. We are proud of that and expect to build membership further.

At this time there are nine organized county alliances in Colorado: Boulder, El Paso, Larimer, Longmont, Mesa , Metro Denver (encompassing Arapahoe, Aurora/ Adams, Clear Creek and Denver counties), Montrose, Otero, and Pueblo. Obviously, there are enough physicians in other counties to support alliances. One of our goals in the next two years will be to organize alliances in more counties. Patti Brown is the CMSA membership chairman for 2000-2001. Patti will be working with CMSA president-elect Maribeth Berry to contact execs and spouses in counties without active alliances to make them aware of the opportunities and advantages of alliance membership.

A second approach to increased membership will be more active recruitment of members-at-large. Maribeth Berry has a special feel for this, as she is one. Physicians' spouses are not limited by the lack of county membership. There is a lot to do and enjoy on the state and national levels. In keeping with the CMSA 2000-2001 theme, "We can do more together," look for CMS Alliance member-at-large membership forms at the CMS House of Delegates in September. They will be available to both physicians and spouses. If your spouse is already an alliance member, please pass a form along to someone who isn't.

The best way to feel part of a group is to participate in its activities. The CMS Alliance has a wonderfully easy project in which everyone can participate with or without a county: corsage cards. These brightly colored business-size cards read, "Have a great time at the dance, but make it a night to remember, not a night to regret. Some decisions last a lifetime." Credit is given at the bottom of the card to the CMS Alliance, your county alliance (if applicable), and "your local florist." They are to be distributed to florists for inclusion in corsage or boutiniere boxes for high school dances. These cards are easy to have printed as Kim Moore, our CMSA S.A.V.E. ***(Stop America's Violence Everywhere)*** chairman formats them as appropriate, mailing or faxing the camera-ready format to whomever is interested. There is CMSA money available upon request to cover the cost of printing. The cards have been well received at all florists approached to date. All King Sooper's florists have been encouraged to use them. High schools have dances primarily in the fall and spring, and there is always a new group of attendees and/or drivers. Won't you join us in encouraging our teens to make good choices? Plan now to distribute corsage cards to florists in your area. We really can do more together.

For corsage card information please contact CMSA S.A.V.E. Chairman Kim Moore at 970-245-0916 or CMSA President Joyce Wilson at 303-699-8411.

For CMSA membership, please be in touch with CMSA Membership Chair Patti Brown at 303-988-0888.

CMS Online

Latest news from Colorado's largest physician organization:

http://www.cms.org

CMS OnLine web page.

MEMORANDUM

Date: **June 21, 2000**

To: Jack Berry, MD, President, CMS
Sandi Maloney, Executive Director, CMS
Richert E. Quinn, MD, Senior AMA Delegate

From: Steve Thorson, MD

Re: My non-candidacy for the AMAAlternate Delegate

This memo is to let you folks know of my decision to not run for re-election as AMA Alternate Delegate.

I've truly "wrestled" with this decision. Although multiple factors have entered the deliberations, the primary consideration is my determination that I'm clearly not well suited for the position.

The friendship and hospitality our delegation and staff have shared with me has been sincerely appreciated.!



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CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the Annual Meeting of the House of Delegates in Aspen, September 22, 2000. We request nominations for the following:

- American Medical Association (AMA) Delegates
- AMA Alternate Delegate
- Colorado Medical Society Speaker of the House of Delegates
- Vice-Speaker of the House of Delegates
- CMS President-elect

Dr. Richert Quinn is running for re-election as AMA Delegate.

Dr. Steve Thorson, is not running for re-election as AMA Alternate Delegate.

Dr. Robert McCartney does not plan to run for re-election as AMA Alternate Delegate.

Dr. Jack Berry is a candidate for election as AMA Alternate Delegate.

Dr. Louise McDonald is a candidate for President-elect of CMS.

Dr. Sherri Laubach is running for election as Speaker of the CMS House of Delegates.

There is currently no nomination for the post of vice-speaker.
If you are interested in being a candidate for any of the above offices, please submit your name and a current resume' to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550. If you have any questions, contact either Sandra Maloney or Debra Jones at 720-859-1001 or 1-800-654-5653.



William Yasushi Takahashi, MD
January 11, 1914 - May 26, 2000

William Y. Takahashi, MD, was born January 11, 1914, at Izumigawa, Japan. His family moved to Seattle, Washington in 1918, where Dr. Takahashi attended public schools and the University of Washington. He became a naturalized U. S. citizen in 1944. He was awarded an M.D. degree from the University of Michigan School of Medicine in 1943. He was licensed in Colorado in 1944 and established his practice in Boulder, where he continued practice in pediatrics until his retirement in 1981.

Dr. Takahashi was active in the Colorado and Boulder County Medical Societies from the time of his election to membership in 1947 until 1985. He was elected a delegate to the CMS House of Delegates from Boulder County Medical Society in 1957, serving in that post until 1961. He was elected a CMS Alternate Delegate to the American Medical Association in 1978.

Dr. Takahashi enjoyed skiing, mountaineering, camping, travel, fly-fishing, golf, gardening, the study of the Japanese sword, classical music and opera. "Taki," as he was widely known, was a life member of the Colorado Mountain Club, a member of the Japanese-American Citizen's League, and a member of the Board of Directors of the Asian Art Association. He took great pleasure in serving the Denver Art Museum as a consultant on Japanese swords. Dr. Takahashi is survived by his wife, Mary, two daughters, Julia and Tama.

Congratulations to . . .



Mack L. Clayton, M.D

Mack L. Clayton, M.D. has been awarded a ***Distinguished Clinical Professorship*** in the Department of Orthopaedics at the University of Colorado School of Medicine. His voluntary efforts as a clinical faculty member to the School of Medicine have spanned the past 40 years.

In 1945, Dr. Clayton received his medical degree at Columbia College of Physicians and Surgeons. He served the United States Army Medical Corps as an orthopaedist from 1946 to 1947 in Manila, the Philippine Islands. The American Board of Orthopaedic Surgery approved his board certification in 1954. Dr. Clayton was in private practice in Denver from 1953 through 1990. Upon his retirement, he was appointed Assistant Chief of Orthopaedic Services at the Veteran's Administration Medical Center, where he continues to provide outpatient orthopaedic care, as well as to teach medical students and residents.

Nationally and internationally, Dr. Clayton is revered for his expertise in hand surgery, especially rheumatoid arthritis surgery. From 1967 through 1980, he was founder and director of an Orthopaedic and Arthritis Surgical Fellowship at the University of Colorado. He trained 33 fellows and many orthopaedic residents in this fellowship. His accomplishments also include production of several audio-visual educational aides, describing his innovative surgical approach to rheumatoid arthritis. In 1998, the International Federation of Societies of Surgery of the Hand bestowed Dr. Clayton with honor of "Pioneer of Hand Surgery". Dr. Clayton has set exceptional standards for quality patient care, finely honed teaching, and significant clinical research. His dedication to the Arthritis Foundation for the past 25 years, his volunteer work in missions in Ethiopia, Egypt and Thailand, in addition to his many other community activities have greatly contributed to the well-being of humanity.

Given Dr. Mack Clayton's life-long, passionate dedication to his career and community service, the award of Distinguished Clinical Professor seems precisely appropriate.

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ROCKY FORD – LOWER ARKANSAS VALLEY - Seeking FP to join small primary care group practice with three offices plus satellite. Breadth of FP, with OB optional. Competitive salary guarantee and fringe package. Collegial atmosphere, great recreational opportunities, good schools and economical housing. Potential for loan repayment. Prefer female. Contact M.J. Berg, MD or Randy Evetts, MPA, (719) 254-7421, fax (719) 254-6966, E-mail MJberg@iguana.ria.net. 06/0300

SEEKING 5TH INTERNIST for 4 internist GP practice. Office & hospital work. Will be immediately busy.
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LAKEWOOD - Busy pediatric office has Immediate opening for Pediatrician. Call (303) 233-7469 ask for Dr. Weiss, Anita or Jill. 03/0600

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EXCEPTIONAL OPPORTUNITY to join a well established otolaryngology practice incorporating Otology, Allergy and Facial Plastic Surgery. Excellent salary and comprehensive benefits for board certified physician. Partnership attainable within two years. Send CV to Paul Dragul, MD & Alan Lipkin, MD, Associates of Otolaryngology, 950 E. Harvard Avenue, #500, Denver, Colorado 80210, Fax (303)-744-1110. 01/0700

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The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

RUMINATIONS

(**def:** chewing again what has chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

What a great way to go!

The doctor shook his head,
And said, "My words are true;
You'll die of hydrophopia;
There's nothing I can do."

The bitter lady sobbed
And then with pad and pen
She wrote a page or two
Until he saw her grin.

"Why grin?" the doctor asked.
"Is this your will you write?"
"Certainly not!" she barked.
"It's folks I plan to bite."

— *Author Unknown*

That little verse came from a book obtained at a neighborhood "yard sale."

Many people get rid of or sell books that have been around for a while. They've either read the books or they're tired of even seeing the book on their shelf. It is fortunate that most books withstand this change of ownership and are available to pass their message on to the next owner, impartially, without losing the value of the message. In fact, with each change of ownership comes the possibility that the new owner will find a totally different value in the books than did the previous owner. This way, we get a lot of milage out of books we never thought of acquiring or even reading.

Not long ago my wife came home with two arm-loads of books, and we both had to look through them to see if any was particularly appealing - you know: judging a book by its cover.

I found one whose cover was totally unappealing, and that is what attracted me to look inside. What I discovered was a virtual treasure-trove of verse, quotations, sayings, sonnets, etc. I was particularly attracted to the sayings which gave directions on how to live life.

For instance:

- If I were to begin life again
  I should want it as it was.
  I would only open my eyes
  a little more.

— *Jules Renard*

Other examples:

- Don't worry if you stumble.
  Only worms never fall down.

or

- Life is like a bicycle — stop peddling and you fall off.

— *Annon.*

We mustn't forget:

An optimist laughs to forget. A pessimist forgets to laugh.

Here's one we can all identify with:

- If your outgo exceeds your income, then your upkeep will be your downfall.

But some of us still try to impress people with the idea that we are something we're not. This adage is painfully true of us all, at one time or another:

- Some idiots spend more than they make on things they don't need to impress people they don't like.

It's never necessary to impress a friend in this manner. Whatever your material shortcomings, friendship is not about that at all. The little book says:

- A friend (is someone who) knows all about you and still likes you.

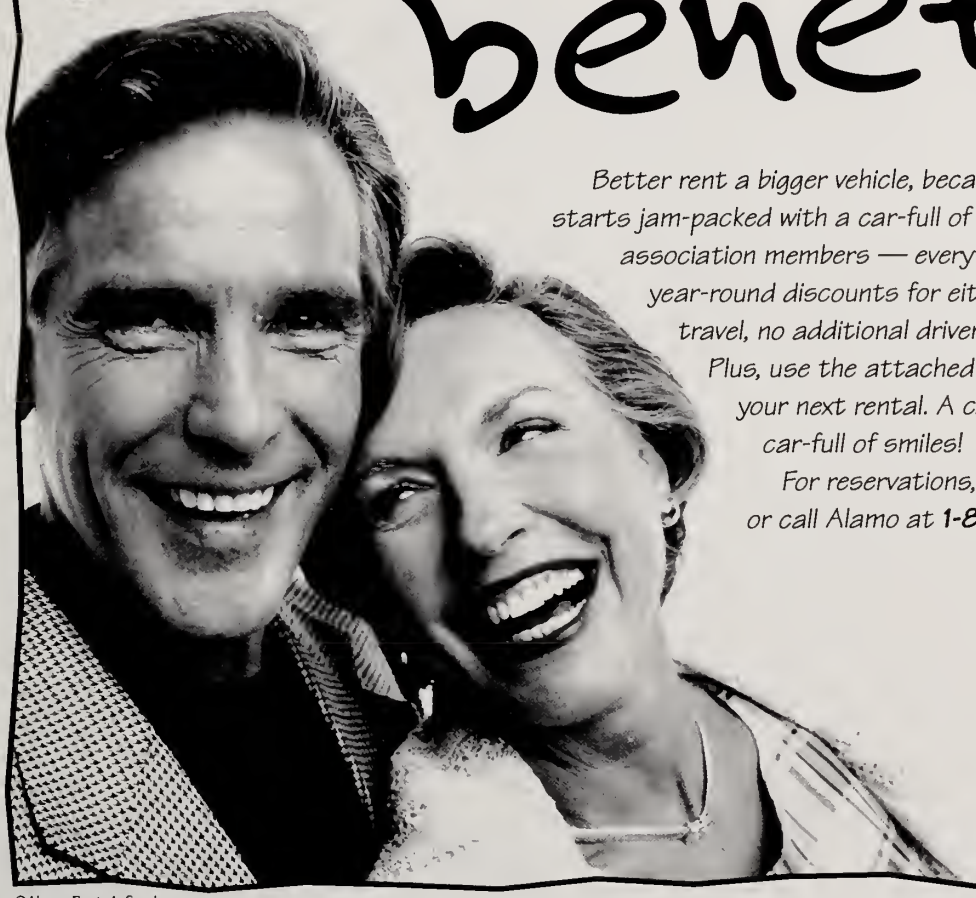
And finally, this gem by an unknown. I found scratched on a crumpled up piece of Spiral notebook paper in a storage box at home. It's written just as I found it:

Yesterday is tomorrow

To speculate time can reverse
would have us rise from grave and hearse
and backward grow into our youth.
A lively thought - I'd like some proof.
Would I then be half egg half sperm
and so on back into a worm?
The world now overpopulated
would find itself decopulated.
Its fauna down to slime and ooze -
a state I'd rather pass than chooze.*
So if big bang's to be reversed
I hope they leave me safely hearsed.
These thoughts can lead to mental stress,
Symptoms which I now confess.

— *Author Unknown*
*Yes, I know, "choose."

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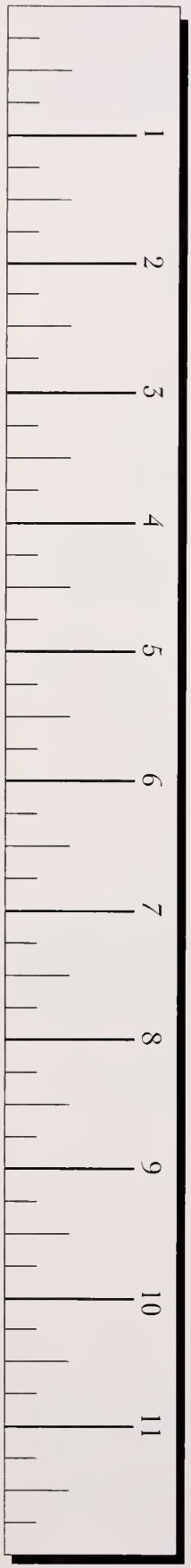
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COLORADO MEDICINE

August, 2000 Volume 97, Number 8



Cover Story

CMS: **THE SOURCE** for the best information in the best interest of Colorado physicians. With publication of the 2000-2001 Medical Office Resource Book, Executive Director Sandra Maloney tells why. Pg. 267.

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Bill Pierson, Managing Editor
Colorado Medicine

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COLORADO MEDICINE (I55N-0199-7343) is published monthly as the official journal of the Colorado Medical 5ociety, 7351 Lowry Boulevard, Denver, CO. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Englewood, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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Colorado Medical Society

How medical education has changed

Medicine has changed in many ways since I graduated from medical school in 1968. The intrusions of business into the professions of medicine and health care have created some of the greatest changes. The problems to patients and physicians resulting from these changes are well known and often discussed. I would like to examine a more positive change that has occurred recently but which is rooted in the problems of several decades ago with an imbalance in numbers and types of medical professionals.

The institution of medical education has made significant progress in the last decade in its quest to educate the physicians and other health-care professionals our society requires. Medical schools and residencies have broadened their focus toward the diversity needed to provide universally adequate access to medical care for all.

During their emphasis on specialization of medical training in the 1950s,'60s and '70s, medical educators seemed to have forgotten the needs of inner city underserved areas and most especially the needs of America's widespread rural populations. This is nowhere more true than in Colorado, where the barriers of significant time and distance to more urban centers impair access to specialty care not practical where population densities are sparse. A re-emphasis on primary care training with diversity of skills has become necessary to serve the medical needs of our society.

Primary care physicians and the ancillary professions they supervise provide 95 percent of the medical care in our state's rural areas. They are essential as a basis for the provision of health care in managed care systems in the inner cities and rural areas, as well. In other developed counties where 50 percent of physicians are primary care physicians, experience has shown the most efficient system for delivery of quality medicine is based upon sufficient numbers of primary care physicians. Such physicians are able to care for most of the patients they see and the basic medical problems with which they usually present, while preserving and utilizing the interhuman relationships that have made medicine an effective art through the last century. This is also the most appropriate arena in which to provide clearly effective and efficient preventive care.

Considering these facts the institution of medical education has come to realize a more balanced approach is necessary to produce both specialty and generalist physicians. While specialty physicians and their skills are certainly needed by medicine and society, the assumption prevalent 20 to 30 years ago that all physicians, even that the best physicians would be specialists, was ill founded and definitely did not serve the needs of society. As a result of pressure from professors and clinical instructors, some subtle some not so subtle, only 15 percent of my medical school class practiced primary care medicine. Medical school curricula were designed around and emphasized specialty training.

". . . for the first time in history, 50 percent . . . are women."

Curriculum changes at medical schools have recognized the imbalance created by previous emphasis on specialization and reemphasized the importance of general medical education. The importance of the personal nature of the physician-patient relationship is being rediscovered as well. Unfortunately, as technological advances in medicine increased, the healing effect of compassionate relationships received less consideration in medical curricula. The resulting loss to the effectiveness of medicine as a whole has been recognized and medical and other health professional educators and schools have integrated understanding of caring and compassionate relationships into the reemphasis on primary and generalist care.

(Continued)

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The University of Colorado Health Sciences Center has provided excellent leadership in this move toward balance in medical education. As a result of its Generalist Initiative during the last six-to-eight years, the numbers of graduating physicians entering primary care residencies approached or exceeded 50 percent each of the last three years.

Another reflection of balance is the fact that for the first time in history, 50 percent of this year's first year class of UCHSC medical school are women. Under served rural communities and inner city areas alike are already beginning to see the results of these changes in medical education in Colorado. We are seeing slowly increasing numbers of young well and broadly trained physicians and other health care professionals interested in practicing or working in rural and urban under served areas.

The institution of medical education nationwide but especially in the more rural western states has recognized the needs of our American society. While remembering the importance to all of us of specialty medicine and the technical advances and the amazing treatment it gives us, medicine is also remembering the value of generalist and primary care medicine. The result will be an improved and balanced health care delivery system that can provide more accessible and higher quality care to our population, rural and urban alike.

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. . . a compilation of medically-related news briefs of immediate interest to the physician community occurring after COLORADO MEDICINE has gone to press. **AT PRESS TIME . . .**

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society



Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Electronic Medical Records and the Health Insurance Portability and Accountability Act of 1996

By Patrick T. O'Rourke
Montgomery Little & McGrew, P.C.

I. Introduction

Imagine two trains. One train, heading north at a hundred miles an hour, is full of medical administrators and physicians who believe that electronic medical records are the wave of the future and will simplify their practices. The other train, heading south at a hundred miles an hour, is full of patient who fear that they are losing control over the privacy of their medical records. Now imagine that those two trains have collided and left it to 535 legislators in Congress to sort out the wreck. Welcome to the privacy regulations for the Health Insurance Portability and Accountability Act of 1996.

When passed in 1996, HIPAA primarily received attention because it would allow greater portability of health insurance benefits when a person left his or her employment. One of the lesser known requirements of HIPAA, however, concerned the confidentiality of electronic medical records. In HIPAA, the Congress directed the Department of Health and Human Services to issue privacy standards that would apply to the exchange of electronic medical records utilized under the Social Security Act. These privacy standards are expected to take effect in the upcoming months, after final approval at the Department of Health and Human Services. Once implemented, they could have a substantial impact upon the manner in which health care providers maintain and transfer their medical records.

II. Transactions Subject to HIPAA Privacy Standards

The provisions of the proposed regulations apply to health plans, health care clearinghouses, and health care providers who create and transmit electronic medical records. The Department of Health and Human Services cannot regulate the entire field of medical records, but it can apply its regulations to health care providers who engage in transactions that have a substantial connection to a federal health care program, such as Medicare or Medicaid. The types of transactions that might bring a health plan or health care provider within the HIPAA regulations could include:

- Submission of claims for payment;
- Coordination of benefits;
- Enrollment and disenrollment in a health plan;
- Health plan premium payments;
- Certifications and authorizations; and
- Injury reports.

When a health care provider stores or transmits any such information electronically, that becomes "protected health information." Protected health information generally includes any information created or received by a health care provider that relates to the past, present or future health of an individual, the provision of health care to an individual, or the payment for an individual's health care. The HIPAA privacy regulations apply to any individually identifiable information contained within those records, once that information has been transmitted or

(continued on next page)

maintained, at any time, in an electronic format. At any time thereafter, the HIPAA privacy standards will then follow the information in whatever form, including paper records and oral communications, in which it exists. The Department of Health and Human Services rationalizes that its standards would be meaningless if a covered entity could convert electronic data to a paper format and then allow that data to be transmitted under less stringent protections.

For example, once an individual's name and diagnostic code were transmitted electronically between a health care provider and an insurance company, both the health care provider and the insurance company would acquire a duty to protect that information in whatever format it might also appear.

III. Duty of Nondisclosure

The general rule created by the HIPAA regulations is that a covered entity must obtain an individual patient's authorization before using or disclosing their health information. For example, this would prevent a covered entity from disclosing patient information to an employer or attorney without the patients express permission. The stated goal of the HIPAA privacy regulations is to make the use and exchange of protected health information relatively easy for health care purposes and more difficult for purposes other than health care.

IV. Exceptions to the Duty of Nondisclosure

Accordingly, the three major exceptions to the consent requirement is that a health plan or health care provider may disclose protected health information without a patient's consent or authorization for the purposes of: (1) treatment; (2) billing; and (3) health care operations.

"Treatment" occurs when health care providers provide health care. Treatment also includes coordination of a patient's health care among providers and the referral of an individual from one provider to another. Health care providers could maintain and refer to a medical record, disclose information to other providers as necessary for consultation, and disclose information as part of referrals to other providers.

"Payment" would mean activities undertaken by a health plan to determine its responsibilities for coverage under a policy or contract. Payment also includes a health care provider's efforts to obtain reimbursement for providing health care.

"Health care operations" are those activities that are "compatible with and directly related to" health care treatment and payment and, therefore, are not within the consent requirements of HIPAA. They include the following activities:

- Conducting quality assessment and improvement activities, including evaluating outcomes and developing clinical guidelines;
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, training programs, accreditation, certification, licensing.
- Conducting and arranging for auditing services, including fraud and abuse detection and compliance programs; and
- Compiling and analyzing information in anticipation of, or for use in, litigation.

Beyond these functional exceptions to the HIPAA regulations' consent requirement, there are a number of "public policy" exceptions are intended to promote key national health care priorities and to ensure that the health care system operates smoothly. For each of these exceptions, the HIPAA regulations would permit, but would not require, the covered entity to use or disclose protected health information without the patient's authorization. The regulations are intended to balance the importance of safeguarding an individual's' confidentiality against the importance of other public activities that require access to protected health information. They include:

- Certain disclosure to public health agencies;
- Certain disclosures to regulatory agencies;
- Certain disclosure to law enforcement officials;
- Certain research activities; and
- Emergency discloses to prevent or lessen a serious threat of harm to another.

Even where a covered entity might not need the patient's authority to disclose protected health information, the HIPAA privacy regulations continue to require that a covered entity make the "minimum necessary disclosure" necessary to accomplish a permitted objective.

V. Prohibited Transactions

Having seen the many exceptions to the nondisclosure requirements of HIPAA, a covered entity might ask for a list of the disclosures that the HIPAA privacy regulations would prohibit without a patient's authorization and consent. Although not an exhaustive list, the following disclosures appear prohibited without a patient's authorization and consent:

- Using protected health information for marketing of services;
- Selling, renting, or bartering protected health information;
- Using protected health information for non-health

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related purposes;
- Disclosing information to employers for use in employment determinations; and
- Using protected health information in fundraising efforts.

VI. Business Partners

Finally, one of the most important requirements of the HIPAA regulations is that they will require health care providers to contractually ensure that its "business partners," such as consulting firms, billing services and other entities that assist health care providers perform their daily operations. Any covered entity's contract with a business partner must among other things:

- Prohibit the business partner from further using or disclosing the protected health information for any purpose other than the purpose stated in the contract;
- Require the business partner to maintain safeguards as necessary to ensure that the protected health information is not used or disclosed except as provided by the contract;
- At termination of the contract, require the business partner to return to the covered entity or destroy all protected health information received from the covered entity that the business partner still maintains in any form and prohibit the business partner from retaining such protected health information in any form;

The Department of Health and Human Services intends to hold health care providers accountable for their business partners' uses and disclosures of protected health information. A health care provider will violate the HIPAA privacy regulations if it knew or reasonably should have known that a business partner materially breached a contract and failed to take reasonable steps to cure the breach or terminate the contract.

VII. Enforcement

Once the proposed regulations are implemented, the Secretary of Health and Human Services will conduct compliance reviews to determine whether covered entities are complying with the HIPAA privacy regulations. At the conclusion of the review, the Secretary of Health and Human Services could bring a civil action to impose significant monetary penalties.

VIII. Conclusion

This article could only begin to discuss the requirements and consequences of the HIPAA privacy regulations. The regulations have not gone into effect yet, but they will almost certainly take effect in the upcoming months. Health care providers may be able to minimize the regulatory impact upon their practices if they begin thinking about the privacy requirements and structuring their business relationships in a manner that will prevent unauthorized disclosures of information. Naturally, these regulations are complicated and voluminous. Once the regulations are passed, legal counsel may be able to assist you in determining whether you need to make any changes within your practice.

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Risky Practices- An HR Workshop
August 23, 2000
Grand Junction, Colorado
St. Mary's Hospital
Contact: (720) 858-6178 or mtreber@copic.com

Compliance Seminar
August 25, 2000
Denver, Colorado
Brown Palace Hotel
Contact: (800) 972-9298 x 121 or (303) 534-0574 x 121

Lawsuit Stress Support Seminars
August 29, 2000
Denver, Colorado
Copic Insurance Company
Contact: Pat Schultz (720) 858-6055

Colorado Dermatological Society Annual Meeting
September 8-9, 2000
Denver, Colorado
St. Joseph's Hospital
Contact: (303) 770-6048

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Update on Infectious Diseases in Primary Care
September 16, 2000
The Antler Adam's Mark
Colorado Springs, Colorado
Contact: (303) 372-9065

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

The Palliative Care Certification Course
October 1-6, 2000
Westin Crowne Center
Kansas City, Kansas
Contact: (316) 263-6380

20th Annual Big Sky Pulmonary & Critical Care Medicine Conference
March 21-24, 2001
Big Sky Ski Resort
Big Sky, Monatana
Contact: (406) 442-6556

THE CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance

The ***CMS Office Manager*** is a genuine Medical Office Resource.

CMS publishes a bimonthly newsletter dedicated to providing the physician's office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on staff analysis of the problems facing the physician's offices. The newsletter is free to the office staff of CMS members, Non members can subscribe to the newsletter at a cost of $75.00 per year.

If you are currently not receiving the newsletter in your office, please copy this form, complete it and fax it to Marilyn Rissmiller at (720) 859-7509, or mail it to P.O. Box 17550, Denver, CO 80217-0550.

Practice Name _____

Specialty _____

Practice Address _____

_____

Practice Phone _____

Practice FAX _____

E-Mail Address _____

Office Manager's Name _____

Office Manager's Address (if different than practice)

_____

_____

Names of physicians in this practice group

_____

_____

_____

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society



The Source

It is certainly not easy keeping up with all the regulatory and public demands on medicine today. That's why it is so important that physicians and their professional associates have a central place where all such information is screened and then forwarded.

We all know it is impossible for any one agency to perform that kind of service today. There are numerous national publications, each of which ascribes to being THE most important medium for health care providers, while others say they are the best source for all physician practitioners. Some cater to the specialty practices. Still others publish for any ancillary group they think they can snag.

We are afloat in information! There's so much of it, we're about to drown. There's no good single way to keep abreast of meaningful information relative to your practice.

The best medium for all physicians, regardless of specialty or subspecialty, is still your professional organization and its publications. Why? Because we can be trusted to have your best interests at heart and have no profit or self-serving motive directing us. I'm certain that many of our members have at one time or another thought that CMS was doing something because it best suited the organization management or executives and not because it was in the best interest of the physician members. That may have seemed the case at one time or another, but it certainly has not been the case since I have been your Society director. "Yes," you say, "but how about those monies CMS receives from vendors that I buy from or use?" CMS does endorse certain services, but only after fairly exhaustive comparisons with other such vendors and yearly reviews of reception of these services by CMS members. The money received by CMS is a direct offset to advertising expense and there is no profit motive involved.

What's your best source of information? Colorado Medical Society; there's no doubt in my mind! What information impacts your practice? Information concerning state and federal regulations; information concerning practice coding; information concerning your protection; information about social and economic aspects of medical practice in Colorado.

The CMS Council on Legislation is your best source of legislative information. The other councils, committees and task forces are also available to you as a resource covering practically every aspect of your medical practice.

The CMS Health Care Financing Division is your best source of practice finance information.

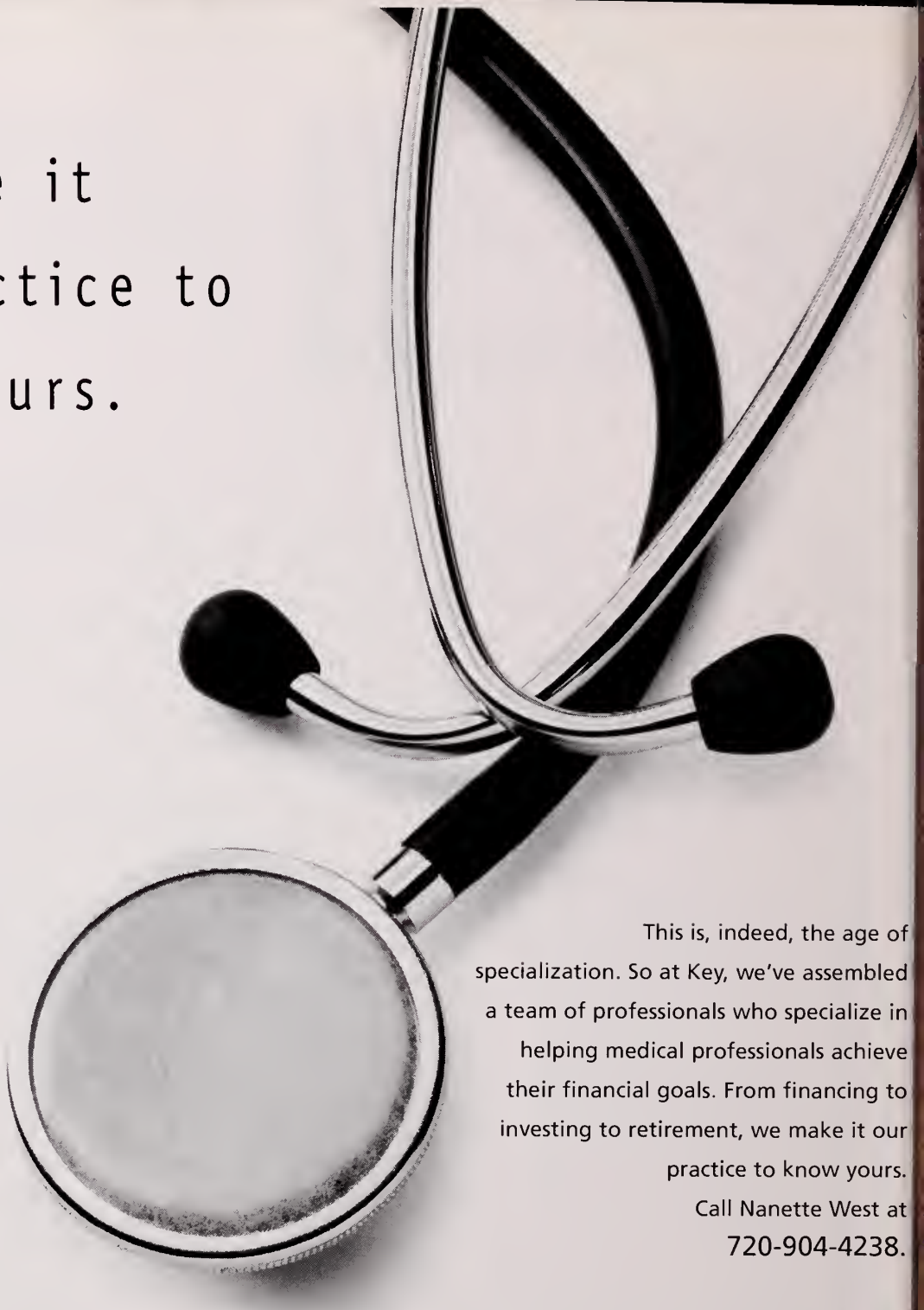
CMS and Copic Insurance Company are the best Colorado resource concerning your protection.

This brings me to another point, and not by accident; CMS has just prepared and published the *"2000-2001 Medical Office Resource Book"*, which is your best source of support from and for your peers; it contains the CMS membership listings as well as a variety of other useful and meaningful information you can get only from your organization: Colorado Medical Society. The book is aptly labeled "The Source." Look for it in your mail soon, if it hasn't already been delivered to you.

So what's the deal with me preaching about a single-source for doctor information? Because I think we are actually about to flounder in this sea of information, unable to pick out what is most important to us, individually. I believe Colorado physicians should be encouraged at every turn to depend on Colorado Medical Society as their best-qualified medium of physician/health care information. As a result, I believe that ***Colorado Medicine*** is the best source for physician-pertinent information. I encourage you to continue to read ***Colorado Medicine*** for this reason alone. I would also encourage you to check out the CMS web page on a regular basis. Our web page is fast becoming a source of immediate information; It is an information channel which we now update regularly and often. CMS On-Line at www.cms.org

We are soon headed into a new year, a year that is going to bring even more change to medical practice. Colorado Medical Society will stay abreast of all information **on your behalf**, and for no other reason. We hope you'll be depending on us.

We make it our practice to know yours.



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You're also paying for something else – peace of mind. A peace of mind that was recently strengthened when The Medical Protective Company became a part of Employers Reinsurance Corporation, a GE Capital Services company. This union solidifies our absolute commitment to the protection of doctors like you. If your most valuable asset, your reputation, is on the line, protect yourself with our unparalleled defense strategy. Nearly 60,000 of your colleagues do. For the Medical Protective representative in your area, call (800) 344-1899.

www.medicalprotective.com

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*Unless prohibited by law.

COLORADO MEDICAL SOCIETY

"Advocating excellence in the profession of medicine"

July 26, 2000

To the Members of Colorado Medical Society:

We are reprinting the following health plan advertisement published by the ***"Coalition for Affordable Quality Health Care"*** and the response by the American Medical Association, not only to keep you informed, but also to let you know how this affects our local efforts. We support the principles that are agreed to in this advertisement. If put into place, these actions would go a long way toward removing many of the current "hassles". However, we do not see these national activities as a replacement for anything we are trying to accomplish on a local basis. We do hope though that this new national philosophy will be an impetus to facilitate acceptance of many of the physician friendly ideas we have already been working on here in Colorado.

Sincerely,

Sandra L. Maloney, Executive Director

P. S. While on the topic of eliminating hassles, I would like to take this opportunity to thank Edie Register and Marilyn Rissmiller of the CMS Health Care Financing Department for their continued efforts on behalf of the CMS physician members.

7351 Lowry Boulevard, Denver,CO 80230-6902 • P.O. Box 17550, Denver, CO 80217-0550
(720) 859-1001 or 1-800-654-5653 • FAX (720) 859-7509 • CMS web page www.cms.org

This is a reprint of an advertisement from the Wall Street Journal

As leaders of America's health plans we understand our actions must speak louder than our words.

The Coalition for Affordable Quality Healthcare is a group consisting of many of the nation's largest health insurers. For the past six months, chief executives and senior representatives of these participating companies have been working on a cooperative effort to improve health care coverage, service and quality for more than 100 million American consumers and their doctors.

Knowing actions speak louder than words, each of the companies participating in the coalition has pledged to support and implement a series of achievable, concrete action steps designed to strengthen the nation's health care system.

On July 12, we agreed to the following:

1. We will enable access to quality coverage and information.
Specifically, that means...
- Direct access to OB/GYN services and pediatricians.
- Coverage of emergency care that a reasonable person would consider an emergency.
- Full and honest communication between physicians and patients about all treatment options, costs and outcome alternatives.
- In the case of disagreement over the medical necessity of tests or treatments, a timely review and a binding decision by an independent, expert physician.
- A wide choice of health care plans with varying levels of coverage and cost.

2. We will simplify administration and improve communications.
We will do that by...
- Promoting the use of web technology by health care companies, consumers and doctors.
- Enabling consumers to conduct certain health care business on-line, such as requesting additional ID cards or asking questions via e-mail.
- Developing a web site to help doctors identify prescription medicines covered by health care plans.
- Adopting a standard benefit grid so consumers can easily compare health care plans.
- Simplifying the credentialing process for physicians by adopting a standard procedure for all health plans.

3. We will work with physicians to improve quality, safety and effectiveness of patient care.
Specifically, we will...
- Join with other medical and health organizations to share information that would result in improved health outcomes.
- Join with physicians to assess current best practices and determine which programs are suitable for industry-wide implementation.
- Partner with, and support, national medical and professional organizations in their efforts to improve quality, outcomes and safety.
- Work together to develop physician-supported, geographic pilot programs to improve quality of care across plans.

This is only the beginning.

In the coming months, we will work with consumers, physicians, hospitals and employers to achieve these goals and identify other areas for improvement. And we will publish regular updates on our progress.

It isn't always easy to accommodate 24 different points of view. But we are committed to the pursuit of a common goal-safe, affordable, accessible health care. And these initial steps are proof of our determination to make it happen.

The Coalition for Affordable Quality Healthcare, www.caqh.org.

Aetna
American Association of Health Plans
Anthem
First Health
CareFirst
Cigna
Empire
FHS
Great West
Highmark
Horizon
Group Health Cooperative
HAA
HealthPartners
Humana
PacifiCare
Right Choice
The Regence Group
Trigon
WELLMARK
WellPoint

AMA: HEALTH PLANS CAN PROVE THEIR COMMITMENT TO PATIENTS BY SUPPORTING A STRONG PATIENTS RIGHTS BILL

We couldn't agree more with health insurers when they say actions speak louder than words. Finally, health insurers seem to realize they have a credibility problem with the public. The way to solve that problem is not with more rhetoric, but with a real commitment to passing a strong patients' bill of rights.

For six years we've worked to pass the common-sense provisions in the patients' bill of rights, and insurers have fought us every step of the way. They've spent millions and millions of dollars trying to derail the Norwood-Dingell Bill. With the passage of a strong bill just one Senate vote away, we question the timing of their deathbed conversion.

At this point, words are not enough. We will judge the sincerity of insurers not by rhetoric, but by results. If insurers show real progress toward ending managed care abuses of patients and physicians, the AMA will be the first to give credit. Tinkering around the edges is not enough, and more rhetoric is simply too little too late.

Insurers have always claimed to put patients first, but their actions have proven that profits are their real priority. If health plans want to prove they care about patients, they'll support the common sense provisions of the patients' bill of rights, so we can all focus on the real priority — the health of all Americans.

Statement attributable to: Randolph D. Smoak, Jr., MD
AMA President

APA: HEALTH INSURANCE INDUSTRY'S PLAN A PR GIMMICK

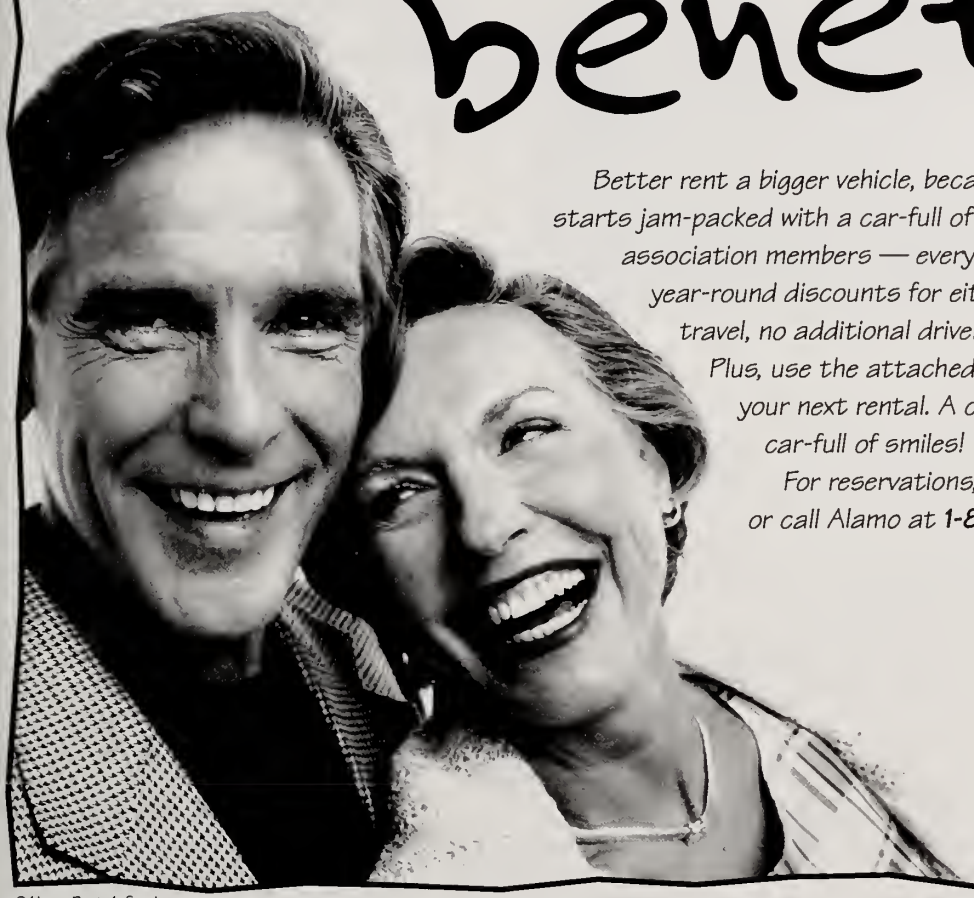
The American Psychiatric Association (APA) labeled the recent health insurance industry's highly promoted and advertised "quality care" proposal as a public relations gimmick, whose true purpose was to derail urgently needed, meaningful national patient protection legislation.

The APA joined the AMA in urging health insurance companies to end their misleading advertising and support the House-passed Norwood-Dingell patients' bill of rights and advocate for it in the Senate.

"We are deeply concerned that their proposal continues to discriminate against people with mental illness (including substance abuse disorders) by not allowing patients direct access to the specialist best trained to provide them medically necessary care -- a psychiatric physician -- without first obtaining a referral from their primary care physician," said Daniel B. Borenstein, MD, APA President.

The American Academy of Ophthalmology (AAO) also questioned the health plans' motives.
"The actions of the industry over the last half decade have shown that they do not want change for the good of patients because they have vehemently fought patients and the medical community on every aspect of a patients' bill of rights," said Catherine Cohen, AAO Vice President of Government Affairs.

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Attention - Colorado Medical Society Members

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COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Be Wary of the Small Frugality

"A man often pays dear for a small frugality."
-- Ralph Waldo Emerson, 1841

Your medical professional liability insurance business is highly sought-after these days. Chances are, you've recently been (or soon will be) approached by insurance companies or their representatives pitching premiums that sound too good to be true. Guess what? They probably are. Let me be clear. I'm not accusing anyone of "bait and switch" tactics. What I am saying, however, is this: experience has taught us that when you let somebody "buy" your business with a low premium, you're trading short-term savings for long-term problems, both for yourself as an individual and for Colorado physicians as a group.

Many of you are old enough to recall the malpractice insurance crisis of the mid 1980s. Many of you are not. But all of you would be wise to review that dark time in Colorado's history...because if you choose to ignore its lessons, you'll be kicking yourself when the promises of low premiums tempting you today converge to create the next crisis.

For example, in the late 1970s and early 1980s, large national carriers wanted to establish dominance in Colorado. Rather than focusing on the long term and on what would be best for Colorado physicians, they tended to take the easy way out by "buying business" - deliberately underpricing coverage to gain short-term market share. After a few years of such tactics, and in the absence of strong risk management to curtail losses, the effects began to be felt.

For individual physicians, the effects were easy to spot. Soon, premiums started nosing upward - perhaps 15% one year, maybe 60% the next - until their "bargain" premiums didn't look so good any more. By that point, the physicians' choices were pretty limited: either 1) pay the increased premiums or 2) modify their practices and stop performing certain procedures in order to qualify for a lower rate class. When physicians felt compelled to modify their practices, it created and in some cases exacerbated problems with patient access to care. When enough physicians were unable to pay the skyrocketing premiums, the national insurance companies closed up shop in Colorado because the business was no longer profitable. Within the space of just a few years, Colorado went from having more than 70 carriers offering malpractice in the state to only two or three. This was a devastating systemic effect, creating a crisis of availability that The Copic Trust and later Copic Insurance Company were formed to solve.

Recent activity in the Colorado malpractice insurance marketplace has convinced us that the patterns of the past are setting up to be repeated. Some of the same players are coming back into the state, singing their one-note song of low premiums. Like before, some physicians will find the lure irresistible. But those who lived through the last crisis - and those who are willing to learn the lessons it offers - will be more cautious and skeptical. I'm confident that there are more of the latter than the former.

CMS Online

Latest news from Colorado's largest physician organization:

http://www.cms.org

CMS OnLine web page.

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COLORADO MEDICAL SOCIETY
BOARD OF DIRECTORS MEETING HIGHLIGHTS

July 21, 2000

- **Copic:** Dr. Jerry Buckley welcomed the Board to the new building and pointed out the pictures in the Founders Board Room of the five founders of Copic Trust. Copic is currently working on a video of the history of Copic. Dr. Buckley thanked Mr. Bill Pierson for his excellent assistance with the video. Copic is going to begin their connectivity application provider service project, which will start in Western Colorado. This project will facilitate physician's offices with computer internet hookups to health plans. They will be able to do referrals, authorizations, claims and eligibility reports. Rocky Mountain HMO is the sponsor of this program on the Western slope.

- **CMSF:** Dr. Jack Berry stated that within the next three years the Colorado Trust will grant one million dollars to the Colorado Medical Society Foundation for the Colorado Rural Outreach Program (CROP). He thanked Dr. Buckley and the Copic Board for their assistance in obtaining this grant. Dr. Cletcher thanked the CMS Board of Directors for their continued support of the CMSF. Dr. Berry expressed appreciation to Ms. Anita Albrecht for her excellent work on behalf of the CMSF. The CMSF now has a web site, which contains information about the Colorado Coalition for the Medically Underserved and the Colorado Rural Outreach Program.

- **CMSA:** Ms. Joyce Wilson stated that the Alliance recently conducted their quarterly board meeting. Ms. Anita Albrecht gave them a presentation on the Colorado Medical Society Foundation fundraisers. This presentation will be given to their general membership in September.

- **AMA Delegation:** Dr. Joel Karlin presented the delegation report in Dr. Quinn's absence. Dr. Karlin stated that the Colorado delegation submitted two resolutions to the recent AMA Annual Meeting in Chicago. He then briefly described some of the resolutions and reports presented at the AMA Annual Meeting. He stated that the AMA House of Delegates voted to allow a non-physician as a member of the Board of Trustees.

- **Medical Executives Group:** Ms. Carol Walker reported in Ms. Judie Watson's absence. Ms. Walker thanked the board for the excellent response received to the Medicare survey. The Medical Executives continue to meet with Medicare. The Medical Executives will present a report on the results of the Medicare survey during the CMS Annual Meeting.

- **CPN:** Dr. Jeremy Lazarus stated that CPN is beginning to enter the Colorado Front Range. Drs. Berry and Allen were speakers at the recent CPN Board Retreat.

- **CFMC:** Dr. Mark Levine briefly described the Colorado Foundation for Medical Care. He distributed a pamphlet describing CFMC's priorities for health care quality improvement through the year 2002.

- Dr. Roderic Gottula presented a report from the Gun Related Mass Assault Task Force. This report will go to the 2000 CMS House of Delegates.

- Dr. Joel Karlin made a presentation on selecting health insurance via a proposed new web site on the internet.

The next board meeting will be held on September 21, 2000 at the St. Regis in Aspen, Colorado.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

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Good News! Our Front Range enrollment now exceeds 23,000, and we anticipate further significant growth in the next two years, with the participation of several large companies including US West, State of Colorado employees, Continental Airlines, and the Public Employee's Retirement Association! Likewise, financial stability appears to improving, although not fully resolved.

As you may know, these developments have resulted in a mailing in mid July to Primary Care Physician's and Specialist's in the Denver Metro and Colorado Springs regions, intended to enhance the partnership between CPN-RMHMO and our physician members. It offered the opportunity to receive a significant increase in reimbursement as of September 1, 2000 if linked with the agreement to pay any remaining initial CPN membership fee (by a small deduction from future reimbursement, or lump sum – at your option), and respond to UM initiatives designed to reduce costs without jeopardizing appropriate care.

Early response has been very supportive, and hopefully the trend will continue. Physicians who choose to decline the proposal will remain CPN members with access to patients with other RMPC products such as PPO and self-funded enrollees.

Our intent is to grow prudently and to grow together. We want to be a significant presence in your practice, both in numbers and in mutual commitment. We are delighted to offer you these new opportunities – and the choice to decide what role you prefer!



Brad Pierson

New. . . to the CSM Staff:

Brad Pierson, the son of Bill Pierson, has joined the staff of Colorado Medical Society in Communications.. Brad has been a computer graphics artist for some 14 years. He was in publishing until, he says, "I burnt myself out. The creative juices dried up." Brad volunteered to come to CMS in February to help out following the departure of Janet Scardamaglia. He came to like the job and the people he worked with so much that he applied for a full-time position. Brad's application was accepted and he began full time on July 1.

Among his duties are the CMS Internet presence, updating the web page and handling new design projects and new links to the CMS page. He also works at composition, design & layout on all CMS publications.

Brad attended George Washington High School in Denver and Colorado State University at Fort Collins. Brad's principal free time activities are camping, softball and weight training. At 6'3" and 200 lbs., there should be a "topping off" some time soon. He knows football, basketball, baseball, softball, soccer, volley ball, tennis and other sports, and was the Denver Broncos spotter for NBC Sports for 12 years. If you don't know what the job of "spotter" is, ask Brad some time.

What do you talk about while taking vital signs?

by Angela Sauaia, MD, PhD, Rich Kessel, PhD, W. William Schluter, MD, MSPH
Colorado Foundation for Medical Care

Involving non-physician staff in diabetes quality improvement

As the Health Care Financing Administration (HCFA) shifts more attention towards the outpatient setting, it will become increasingly important to utilize all office staff to ensure continuous quality improvement with minimum impact on physician time and patient flow. Jane Reusch, MD, chair of the Diabetes Advisory Council at the Colorado Department of Public Health and Environment, addressed this issue while discussing quality improvement at CFMC's Diabetes Study Group in February. During her presentation, she suggested we more fully involve non-physician staff members in the improvement process. She went on to ask, "After all, what does one talk about while taking vital signs?"

It is a valid question. Where does it state that this has to be meaningless banter? While small talk is a good rapport builder with new patients, diabetes is a chronic disease which necessitates frequent office visits. Patients want information and they want to be reassured that they are getting the best possible care. Time spent with non-physician staff during frequent visits provides a great opportunity to educate patients about diabetes care and to ensure follow through with recommendations without adversely impacting patient flow.

CFMC is always looking for new ways to maximize the benefit of each patient encounter. As part of our quality improvement activities in diabetes well-care, we recently mailed toolkits with educational materials to all primary care physicians in Colorado (see *Colorado Medicine*, February 2000).[1] Each kit contained a sample flow-sheet which allows physicians to track routine care and lab values for patients with diabetes. While intended for physicians, the flow-sheet could be completed almost entirely by non-physician personnel just by asking a few questions while taking vital signs! A quick glance during the patient encounter would then allow the physician to detect gaps in the patient's routine care (e.g., no dilated eye exam during the past two years), prompt an educational discussion, and lead to the necessary corrective action.

How can non-physician staff be best incorporated into the patient education and monitoring process? Several managed care organizations have already agreed to recruit physician offices to participate in a new quality improvement project designed to answer this question. Focus groups with non-physician staff are being organized by CFMC. These groups will address the basic questions of; how are the diabetes toolkits being used in physicians' offices; how can we assist in improving the use of these educational and monitoring materials; what other materials/activities could be used to assist non-physician staff in improving diabetes care; and "what do you talk about while taking vital signs?" A dozen offices will be recruited to participate in this pilot intervention with representatives from non-managed care practices also invited to ensure generalizability.

The results of these focus groups will provide us with initial direction from which we intend to design multiple interventions to be piloted in the participating practices. Effects of the interventions will be assessed using quantitative administrative data which corresponds to the HCFA defined diabetes care national priorities (i.e., hemoglobin A1c testing, lipid profiling and dilated eye exams). Use of administrative data will minimize the burden on already overworked physician offices and allow for the office to continue to track their performance after the project is completed.

As with the management of diabetes, continuous measurement is crucial to the successful management of quality improvement. One of the goals of our outpatient projects is to empower patients to take charge of their diabetes care. A second goal is to empower practices to maintain their quality improvement efforts and continue to measure their efforts with minimal assistance. Practices, like patients, need to take pride in their success.

A consistent theme in this column has been our call for active provider participation. As always, we welcome questions, suggestions, and, of course, volunteers.

CFMC
2851 S. Parker Road, Suite 200
Aurora, CO 80014-2713
303-695-3300

[1] ***All materials are available at no cost on our web site, www.cfmc.org***

Fall Clinics
of Montrose, Colorado

Over 100 physicians from Colorado and several neighboring states will gather in Montrose to participate in the 29th Annual Montrose Fall Clinics on September 29 and 30, 2000. The Fall Clinics are sponsored by the Montrose Memorial Hospital and its medical staff.

Guest speakers will present various medical topics during the meetings, which will be held at the Montrose Pavilion, 1800 Pavilion Drive.

Registration will begin at 8:00 a.m. on Friday, September 29, with lectures throughout the day, and from 8:30 a.m. through 12:30 p.m. on Saturday, September 30.

Scheduled to speak at this clinic are:

- **Bahri Bilir, M.D.**, Medical Director, Centura-Porter Liver Transplant Program, Clinical Gastroenterologist, Arapahoe Gastroenterology, Denver, Colorado
- **Glen M. Bowen, M.D.**, Associate Professor, Department of Dermatology, University of Utah, Salt Lake City, Utah
- **Richard C. Fisher, M.D.**, Associate Professor and Practice Director, Department of Orthopedics, University of Colorado, Denver, Colorado
- **Javier F. Magrina, M.D.**, Professor and Chairman, Department of Obstetrics and Gynecology, Mayo Clinic, Scottsdale, Arizona
- **Steve H. Parker, M.D.**, Assistant Clinical Professor, Department of Radiology, University of Colorado Health Sciences Center, Medical Director, The Sally Jobe Breast Centre, Denver, Colorado
- **C. William Schwab, M.D.**, Professor of Surgery, Chief, Division of Traumatology and Surgical Care, University of Pennsylvania Health Systems, Philadelphia, Pennsylvania

Topics discussed at the Clinic will be:

- ABC's of Hepatitis
- Complications of Liver Cirrhosis
- The Diagnosis and Management of Pigmented Lesions and Melanoma
- Dermatological Look-Alikes and Their Pitfalls
- Developing World Medicine and the Fear of Big Numbers
- The Management of the Atypical Pap Smear
- Office Management of Ovarian Cysts
- Minimally Invasive Breast Biopsy
- Breast Ultrasound Pathology
- Violence in America: Medical Aspects
- Injury Amongst Our Elders

The participants as well as the guest: speakers will discuss interesting case presentations at the end of Saturday's program.

In addition to the medical lectures, participants will have the opportunity to visit over 50 pharmaceutical displays by various drug companies. These provide the physicians the opportunity to discuss new products and techniques with the company representatives.

Eleven hours of Category I AMA credit will be given to those attending this Clinic.

The Annual Fall Clinics Awards Banquet and dance will also be held at the Pavilion on Friday evening. Entertainment will be provided by Rick Marshall, "The Coach", and dancing will follow the entertainment. The post conference retreat will include a barbecue at The Inn at Arrowhead.

Persons who would like further information on the clinic may contact Kathy Holman at the hospital, 970-240-7397.

Bioterrorist Exercise Highlights Need for Partnerships

by Richard E. Hoffman, MD, MPH and Mark D. Estock, MPH
Colorado Department of Public Health and Environment

Bioterrorist attack!

". . .pneumonic plague in over 2,000 persons."

From May 20-23, 2000, local, state and federal officials in metro Denver, along with three hospitals, participated in a mock bioterrorism exercise named Operation Topoff. Just two months earlier Governor Bill Owens signed House Bill 00-1077, a bill sponsored by Representative John Witwer and Senator Ken Arnold, that addressed the response to bioterrorism and pandemic influenza in Colorado. Operation Topoff was an opportunity to see how the new law worked and to learn how to coordinate the medical, public health, and law enforcement efforts that would be occurring simultaneously.

As the simulated bioterrorist attack unfolded in the Denver metropolitan area, it was discovered that a terrorist had covertly released an aerosol of Yersinia pestis (plague) at the Denver Performing Arts Center on Wednesday May 17. This exposure led to pneumonic plague in over 2,000 persons. There were many deaths and hundreds of secondary cases—all simulated. Local and state resources were exhausted by patients filling hospital emergency departments, regular beds, critical care units, and morgues. Twenty-four hours into the simulation emergency response teams from TriCounty and Denver health departments, the State health department, and the State emergency operations center and specialty units from the Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services and eight other federal agencies had been activated. Federal assistance included plague experts from the CDC Ft. Collins facility, Disaster Medical Assistance Teams, and a large shipment of antibiotics from the national pharmaceutical stockpile.

Hard decisions had to be made. Who would receive antibiotics? Would a quarantine order be issued? What messages would be communicated to the public? How would corpses be handled for both legal purposes and personal burial? The Governor has authority to make these decisions, but House Bill 00-1077 created an Expert Emergency Epidemic Response Committee to advise the Governor on these difficult issues.

The formation and work of the Committee is at the heart of this new legislation (see 24-32-2104, C.R.S.). Members of the Committee include the presidents of the Colorado Medical Society, the Colorado Health and Hospital Association, and the Board of Health, along with the State Veterinarian, a wildlife disease specialist with the Division of Wildlife, the Attorney General, a pharmacist member of the Board of Pharmacy, the Director of the Office of Emergency Management, and from the State health department: the Executive Director, the Chief Medical Officer, the State Epidemiologist, the Chief Public Information Officer, and the Emergency Response Coordinator. In addition, the Governor will appoint an infectious disease specialist, a medical examiner, an emergency medicine physician, a hospital infection control practitioner, and a specialist in post-traumatic stress management. Members of the Committee were given legal immunity for decisions of the Committee (see 24-32-2111.5, C.R.S.). Some temporary members were appointed before Operation Topoff began, and the Committee met via telephone conference for several hours each day of the exercise.

The intents of the new law are to assure that the Governor receives the best possible expert advice, to plan a coordinated response to a large epidemic, and to remove potential legal barriers that impede the public health and medical sectors from working together for the community. In addition to establishing the Expert Committee, the new law provides a

comprehensive preparation and response capacity by:

- Charging the Committee to develop a supplement to the state disaster plan regarding the prioritization and distribution of antibiotics, antivirals, and vaccines that may be needed and in short supply during a large-scale epidemic.
- Providing civil and criminal immunity to hospitals, physicians, health care providers, and managed care health care organizations that fully comply with executive orders of the Governor and rules of the Board of Health.
- Including physicians, health care providers, emergency medical service providers, and public health workers in the definition of "civil defense worker" so that the volunteer worker or his/her survivors may receive compensation if the worker suffers an illness (e.g. plague or influenza) that is the cause of an emergency epidemic.
- Authorizing the State Board of Health to adopt rules to assure that hospitals, trauma centers, local public health departments, and managed care organizations are prepared for an emergency epidemic.

This legislation is but one part of overall epidemic preparedness efforts. Primary care physicians and other health care providers will be essential for the early recognition of an epidemic or bioterrorist attack. A critical element needed to complete the preparedness plan will be private health care providers. Last year during testimony before the Congress, Dr. John Bartlett (at the time he was the President of the Infectious Diseases Society of America) noted that "civilian health care workers represent an important — in fact probably the most important — component of the response to bioterrorist activities using a microbial agents."

To report any suspicious disease or syndrome potentially related to a bioterrorist event, please call 303-370-9395 (24 hours/7 days).

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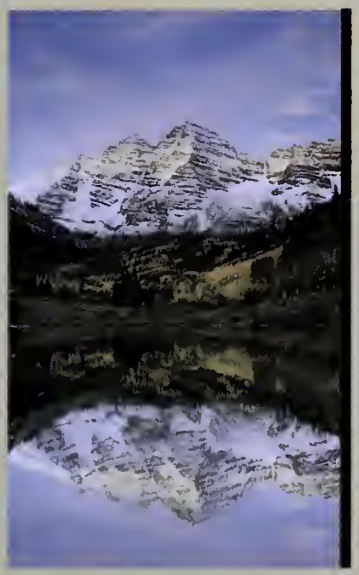
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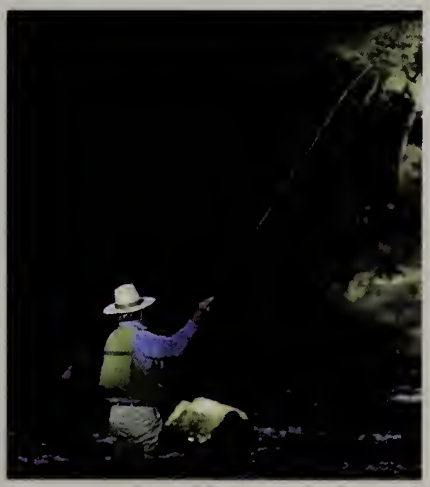
CMS Annual Meeting

September 22-24, 2000

St. Regis Hotel

Aspen







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2001: a Medical Odyssey



CMS Annual Meeting



COMPAC Luncheon

Friday, September 22, 2000

If you haven't already done so, make plans now to attend the COMPAC luncheon on Friday, September 22. Because COMPAC is funded through contributions, not your CMS dues, there is a $35 charge for COMPAC members and a $45 charge for non-COMPAC members to cover the cost of the lunch.

The COMPAC Luncheon will provide a unique opportunity this year. The COMPAC Board of Directors is pleased to announce that Colorado Speaker of the House Russell George and Speaker Pro Tem Bill Kaufman will be joining us for lunch. They are both term limited and will not be returning to the legislature in January 2001. This will allow them to "let down their hair" and give all those in attendance a candid appraisal of Colorado's political landscape. They are expected to discuss the pressure that legislators receive from extremist groups (coming in all shapes and sizes) and advise organized medicine on becoming a more effective player in Colorado's political process. This presentation will be invaluable and provide a rare glimpse behind the scenes of Colorado politics. Do not miss it!

Advocating Excellence in the Profession of Medicine

Colorado Medical Society Annual Meeting Educational Program

Who: This activity is designed to address needs and interests of Colorado physicians from all specialties. Others who have interest, are welcome to attend (e.g., ancillary staff, medical executives of component societies, and other guests and attendees of the CMS Annual Meeting).

What: What we want to accomplish, and how we will know it is accomplished:
1) Demonstrate, overall, that although there may be disagreements among physician groups on various issues, the delivery of high quality care is and will remain an unwavering area of common professionalism amongst physicians.
2) Each segment will have specific objectives based on the area of quality chosen (in progress). The audience will be asked to evaluate achievement of those objectives. Each presenter will be asked to integrate ethical considerations, future CME needs and how the use of technology (when applicable) is facilitating the work.
3) This will be a continuation of a theme set by CMS President-elect Dr. Richard Allen for his presidential term: Rediscovery and re-definition of medical professionalism through discussion and provision of information on ethics, the science of medicine and education.

Emphasis will be placed on quality improvement and control programs now in use in a variety of applications.

Why: The recent Institute of Medicine Report regarding "medical errors" was sensationalized in the public press by implying that medicine has been negligent in the delivery of care to patients. By looking deeper into the report, it is discovered that 99% of "errors" are the result of system failures, and not caused by individuals or an individual group (e.g., physicians). In Colorado, there are several major physician organizations, all of whom have one common, agreed-upon goal: the delivery of high quality medical care to the people of Colorado. We wish to provide an educational program that gives each of these groups a forum for presenting work being done by their organization in this important area. It will serve to publicly profess that physicians do not deny that errors occur, and, in fact, continuously work to improve the delivery of care to patients.

Accreditation and AMA Category 1 Credit

1) The Colorado Medical Society is accredited by the Accreditation Council for CME to sponsor continuing medical education for physicians.

2) The Colorado Medical Society designates this continuing medical education activity for up to 5.0 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit actually spent in the educational activity.

Education Program

Colorado Medical Society Annual Meeting

Saturday, September 23, 2000
7:30 a.m. - 12:45 p.m.
The St. Regis Hotel - Aspen, CO

"Advocating Excellence in the Profession of Medicine"

7:30 AM- 7:35 AM	Welcome	Richard Allen, MD
7:35 AM- 8:20 AM	Medical Professionalism	Matt Wynia, MD, AMA
8:25 AM- 9:10 AM	Professional Accountability	Ned Calonge, MD, BME
9:15 AM-10:00 AM	Under use, Over use, Timeliness	Will Schluter, MD, CFMC
10:05 AM-10:50 AM	Joint Data Project on Careful Use of Antibiotics	H. Dennis Waite, MD,CMS
10:55 AM-11:05 AM	Six Key Principles for Effective Risk Management	Alan Lembitz, MD, Copic
11:05 AM-11:15 AM	Copic's Breast Cancer Project	Marjie Harbrecht, MD, Copic
11:15 AM-11:25 AM	Copic's Dimensions of Medical Outcomes Project	Jeff Varnell, MD, Copic
11:25 AM-11:40 AM	Q and A with the Copic presenters serving as panel respondents.	Drs. Lembitz, Harbrecht & Varnell
11:45 AM-12:30 PM	Organizing a Large Academic Group Practice to Improve Quality	Joel Levine, MD, UCSM
12:30 PM-12:45 PM	Closing Remarks/Evaluation	Richard Allen, MD and Matthew Wynia, MD



COLORADO MEDICAL SOCIETY
YEAR 2000 FINANCIAL WORKSHOP

Saturday, September 23, 2–5p.m.

Presented by Copic Financial Services Group

"SO YOU WANT TO BUY OR SELL YOUR PRACTICE?"
PEARLS AND PITFALLS

A CASE STUDY



I. 2:00 - 2:15PM - Year 2000 Mission - Physician Services
Richard R. Ellis, Jr. - Executive Vice President
Copic Financial Service Group

II. 2:15 - 3:00PM - Tasks Necessary to Buy or Sell a Practice
Leon B. Harrison CLU - Copic Financial Service Group

- The Current Medical Practice Environment
- Equity Purchase - What Will it Cost - How do I Pay for It?
- Separating Professional Goodwill From Practice Goodwill
- Goodwill Requires Enforceable Covenant Not To Compete
- Financial Projections/Proforma Reports/Feasibility Studies - For Line of Credit/Equipment Acquisition and Working Capital Financing

III. 3:00 - 3:30PM -How to Fund Your Equity Buy/in - Buy/out
Mike Edwards CFP Copic Financial Service Group

- What is Being Bought/Sold - Assets or Stock?
- Buy/Sell Agreements - What will it Guarantee?
- How Practices Phase Out Their Older Doctors
- Deferred Compensation - A Way to Receive Goodwill?

IV. 3:30 - 3:45PM - Break

V. 3:45 - 4:30PM - Tax Traps to Avoid
Leon B. Harrison CLU - Copic Financial Service Group

- Physician Employment Agreement Income Distribution
- Section 1060 (e) Issues - *LOOKOUT!*
- Stark I-II/Fraud and Abuse Landmines
- What to do When Negotiations Begin to Show Promise

VI. 4:30 - 5:00PM Open Question/ Answer Workshop

Annual Meeting Registration

2000 Annual Meeting of the Colorado Medical Society
St. Regis Hotel • Aspen • September 22-24, 2000

Name (please print) _____

Component Society _____

Name of Spouse/Guest(s) _____ **CMS Alliance Member** ❑**Yes** ❑**No**

*If you are not a member of CMS, please provide the following information and **$125** for registration fees:*

Company/Organization _____ **Title** _____

Registration deadline is September 11, 2000. Registrations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. *(Note:* If you have not pre-registered for Saturday's dinner/dance, you must do so before noon on Friday, Sept. 22 at the Registration Desk.)

Complimentary Events for CMS Member & Spouse/Guest
Except for the COMPAC/Alliance Luncheon, you and one guest are entitled to attend all events at no charge. To confirm your reservation, use the boxes below for yourself and one guest and the shaded area for additional guests.

Thursday, September 21	member	spouse/guest
6:00 pm Welcome Reception	❑	❑

Friday, September 22	spouse/guest
8:00 am Alliance Breakfast	❑

Saturday, September 23 *(Complimentary for member & one guest **only**)*			**CHARGES FOR ADDITIONAL GUESTS**
7:00 am Breakfast Buffett	❑	❑	# _____ @ $25/each _____
8:00 am Education Program	❑	❑	
12:45 pm AMA Forum Luncheon	❑	❑	
7:00 pm President's Dinner Dance			
Meat dinner	❑	❑	# _____ @ $95/each _____
Vegetarian Dinner	❑	❑	# _____ @ $95/each _____
Vegan Dinner	❑	❑	# _____ @ $95/each _____

Other Events

Friday, September 22 | * CHARGE PER PERSON FOR **ALL** MEMBERS AND GUESTS

12:30 pm COMPAC/Alliance Luncheon

#_____@ $35/each*_____ COMPAC Member

#_____@ $45/each*_____ Non-COMPAC Member

Please make check payable to: **Colorado Medical Society** and mail this form.

TOTAL amount enclosed for non-members, additional guests and COMPAC Luncheon. **$** _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 720-859-1001 or 1-800-654-5653); or fax it to us (at 720-859-7509).

Hotel Reservation deadline is 8/13/00.



TEE UP!

Entry Form

CMS Annual Meeting Golf Tournament
Aspen Golf Course
Thursday, September 21, 2000



Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____

Home Phone _____ Fax Number _____

E-mail Address _____

While in Aspen I will be staying at _____

My golf handicap is _____ or My average score is _____

I prefer to be teamed with _____

If you would like to play, please return this entry form as soon as possible because space is limited.



Tournament tee times are reserved starting at 8:08 am. Foursomes to choose their own type of play (scramble, individual, etc.). Prizes to be awarded for individual contests (long drives, closest to the pin, etc.) Foursomes will be arranged; please specify if you have a preference of partners. To ensure tournament registration, please send entry form and advance payment of $130 by September 1, 2000 to:

Barbara Campbell, 2251 Ash Street, Denver, CO 80207. For more information please call Barbara at 303-388-5307 or email to BarbLRA@aol.com.

Annual Meeting Schedule

The St. Regis Hotel-Aspen • September 22-24, 2000

Thursday, September 21st

8:00 am	CMS Office open
8:00 am	18-hole Golf Tournament - Aspen Golf Course
1:00 pm-2:00 pm	Finance Committee
2:00 pm-5:00 pm	Board of Directors
4:30 pm-7:00 pm	Registration open
6:00 pm-7:30 pm	Welcome Reception Dinner on your own

Friday, September 22nd

7:00 am	CMS Office opens
7:00 am-4:00 pm	Registration
7:00 am-7:45 am	Reference Committee Breakfast
7:00 am-7:45 am	New Delegate Orientation
7:00 am-7:45 am	Rural Physicians Forum
7:00 am-8:00 am	COMPAC Board
7:45 am-8:00 am	Credentials Committee
8:00 am-8:30 am	Opening Session - House of Delegates
8:00 am-9:30 am	CMS Alliance Breakfast
8:30 am-12:15 pm	General Membership Meeting
9:30 am-12:00 N	CMS Alliance Membership Meeting
12:20 pm-1:45 pm	COMPAC/CMS Alliance Luncheon
2:00 pm-3:00 pm	Copic Risk Management (E.M.R.)
2:00 pm-3:00 pm	Copic Risk Management (Radiology)
2:15 pm-4:30 pm	Reference Committee
3:15 pm-4:15 pm	Copic Risk Management (Surg. Sub. Specialties)
3:15 pm-5:15 pm	Reference Committee
6:30 pm-7:30 pm	Colorado Chapter, American College of Physicians/American Society of Internal Medicine (ACP/ASIM)
7:00 pm-9:30 pm	Gone But Not Forgotten Dinner (by invitation only)

Saturday, September 23rd

7:00 am	CMS Office opens
7:00 am-11:00 am	Registration
7:00 am-7:30 am	Breakfast
7:30 am-12:45 pm	Education Program
9:00 am-11:30 am	CMS Alliance Program
10:00 am-10:30 am	Break
12:50 pm-1:55 pm	AMA Forum Lunch
2:00 pm-5:00 pm	Copic Financial Seminar
5:30 pm-6:15 pm	Meet the Candidates Reception
6:15 pm-7:00 pm	Inaugural
7:00 pm-10:30 pm	Presidents' Dinner/Dance
8:30 pm-10:00 pm	Copic Dessert Reception

Sunday, September 24th

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 am-9:30 am	Registration
7:00 am-8:30 am	Component Caucuses (Arapahoe, Aurora-Adams, Boulder, Clear Creek Valley, Denver, El Paso, Larimer/Weld, Pueblo/Western Slope)
8:15 am-8:30 am	Credentials Committee
8:30 am-12:00 N	Closing Session House of Delegates
12:00 N or immediately following HOD	Reorganizational Board

Dine & Dance
to the music of
Colorado Power Company



at the
President's Dinner-Dance

Saturday Night, September 23rd: Reception from 5:30 - 6:15, Presidential inaugural 6:15 - 7:00. Dinner at 7:00.

The ***Colorado Power Company*** *is a 9-piece band that plays a variety of music from the Swing Era and Neo/Swing to Latin, Classic Rock, and some Country.*

The band includes the piano, upright and electric bass, drums, guitar, saxophone/flute/clarinet, 2 trumpets, trombone, and female vocalist. Five members of the band are also vocalists. ***Colorado Power Company*** *is from Carbondale, Colorado, and performs at many Aspen Valley functions. Directed by Bill Parish, the Colorado Power Company is a well-known and popular music group.*

COLORADO MEDICAL SOCIETY ALLIANCE
FALL MEETING

St. Regis Hotel, Aspen
September 21-23, 2000

The Alliance fall meeting is shaping up to be an exciting one in 2000. The St. Regis is a gracious setting for our special time together. We will use a 1950s theme to celebrate the fiftieth anniversary of the AMA Foundation. Come prepared to enjoy it by wearing your favorite '50s style clothes at the Thursday dinner board meeting and at the general meeting on Friday as well. Use your memory or your imagination and join the fun.

We will have two special speakers. As always, an AMA Alliance speaker will join us. This year's speaker will be Mrs. Barbara Jett, one of the AMA Alliance Field Directors who will speak on leadership and membership in your alliance year.

Our second guest speaker will be Mr. Jim Hillhouse from Copic who will speak on ***The ABCs of Retirement Planning for Spouses- Minimizing Mistakes-Maximizing Fulfillment of Your Dreams and Aspirations.*** Jim is Copic's SEC Registered Investment Advisor and is experienced in managing investments. He will leave fifteen minutes for questions, so be sure to have them ready.

CMS ALLIANCE FALL MEETING 2000
REGISTRATION FORM

Registration fee: $25 per person ..... $_____

Thursday, September 21
6:00 p.m. Highlands Room
Dinner and board meeting (including county presidents) $39.00 ..... $_____

Friday, September 22
8:30 to 9:15 a.m. (Room to be announced)
Continental breakfast (No charge, but you **must** rsvp) ..... _____

9:15 to 12:00p.m. (Room to be announced)
2:00 to 5:00p.m.
General meeting and workshop ..... _____

Saturday, September 23
Morning- casual get together: No charge

Total: registration and meal (if applicable) ..... $_____

Mail this form with your check to Donna Foss 1675 S. Fairfax St., Denver 80222
Your check is your reservation.

by Bill Pierson
Managing Editor
(CMS Historian,Dr. John Lightburn, was on vacation this month)

R. H. Denney - "Village Doctor 68 years."



H. R. Denney, MD
1872-1968

In 1997 I had the unexpected pleasure of physically stepping back in time to the life and profession of a "pioneer" rural Colorado physician, Dr. Robert H. Denney. Dr. Denney had passed away many years before (1968) after practicing medicine in Elbert, Colorado for 68 years. Elbert is located southeast of Denver in Elbert County, a few miles south of Elizabeth. In the days Dr. Denney practiced there, this was corn, wheat and livestock farming country, not big western ranches but more like the early homesteaders who staked out a plot of 124 acres and started plowing and planting.

Dr. Denney officed in his home throughout all those years he practiced. It so happened that one of the Denver commercial bank trust departments contacted me because they didn't know what to do with what they had found in an estate they were handling. They told me that it was the home of the son of a physician, and the son had recently passed away. He had been living in the family home in Elbert for several years. I was told there were medical records and possibly some controlled substances which needed to be dealt with, not to mention much evidence of a very early Colorado medical practice. The bank didn't know how to handle these things and thought it best that CMS be involved. Being the "historical snoop" that I am, I was delighted!

When I arrived with the trust officer in Elbert I was amazed to find a physician's office, waiting room, examination room and minor surgical facility along with the doctor's pharmacy insitu, as if it all had just closed from a normal day's business last week.

I was aghast...absolutely amazed! How could this happen? How could such a precious, priceless piece of Colorado's medical history have survived in such condition?

I walked up the porch steps of this typical rural, small town home. It was nominally a three bedroom house with earthen basement. The office door to the right of the home's front door, announced in gold leaf lettering on the glass, "R. H. Denney, MD - Office" Just inside was a waiting room with three straight-backed matching chairs, a long table against the wall for magazines, and a single ceiling light in the center of the room.

There was an outbuilding, a stable cum garage (much storage in the former hayloft, such as 14 complete years of the Journal of the American Medical Association). The garage housed a 1960s car which was in excellent condition itself.

There were many reminders of the Denney family presence. What was something of a mystery was how this all came to be left as it was.

It was only through chance that this happened. A son, Robert H. Denney, Jr., had been employed by a Denver bank and had never relinquished the family property in Elbert. When Mr. Denney retired, he moved to Elbet to live. He was single, pretty much a loner, and spent much of his time traveling, He left the house and contents entirely as they were when his parents still lived there, with the exception of his use of the kitchen and one bedroom.

CMS Archives had on file a letter from the Denney's only daughter, Mrs. B. Loren Gleason of Colorado Springs, recounting the Denney's 60th wedding anniversary celebration on January 6, 1959. In her tribute, she also told the story of Dr. Denney's long practice in Elbert. Mrs. Gleason's colorful account, and pictures of the office and house as they were found in 1997, are reprinted on the following pages. Colorado Medical Society felt it only fitting that once the medicines were properly destroyed and the patient records were safeguarded that the entire medical office be given to the Kiowa County Historical Society. We hope at this time that all of the elements are on display for the public.

The late Dr. & Mrs. Denney are a tribute to the hardy physician families in early rural Colorado.

(Continued)



Many people came to the front of the Denney house in Elbert, Colorado. They came to see "Doctor" in his office/exam room to the right of the front entrance of the house. Dr. Denney had to rebuild his home after the flood of 1935, and he planned it so that his home also included his office and treatment facilities.

"60th Wedding Anniversary"*

The three communities of Elbert, Kiowa and Elizabeth honored the 60th wedding anniversary of Doctor and Mrs. R. E. Denney on January 6th, 1959. The Elbert Presbyterian Church and the Aid Society, and the Elbert community each sent a floral tribute in recognition of Mrs. Denney's years of work and service to the church, and of the Doctor's years of service to the Community.

"Doc" came to Kiowa in 1891, a year or two after graduation from high school in his native Ohio, making his headquarters with his aunt and uncle, Frank and Emma Long. He taught a summer school in the Kiowa district in the one room school then near the old George Katherine place, a winter term in the Aldus District on Commanche Creek, then a winter term in the Lake Gulch District west of Elbert, and one term at the Jones School at the Colorado and Southern railroad milk stop, Rocky Butte, between Elbert and Elizabeth. This was the year of the disastrous October 12th blizzard.

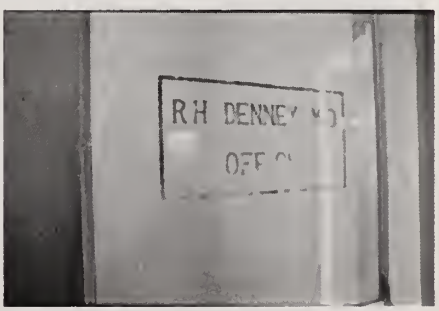
While teaching this school Denney was "reading" under Doctor Neiland at Elbert in preparation for entering medical college, making weekly trips in the evenings to study various premedical courses. In 1896 Robert Henry Denney received his Doctor of Medicine degree from the Gross Medical College of Denver, and opened his practice of medicine in Elbert, buying out Dr. Murray who had been practicing in Elbert two or three years. There were three medical colleges in Denver at that time, The Gross, The Denver, and` The Colorado Medical College; later the three combined in today's school of medicine of Colorado University. At that time the west end of Elbert County was served by seven doctors of medicine, two in Elizabeth, one in Kiowa, one in Eastonville, two in Elbert, and at one time there was a M. D. in Fondis.

On January 4, 1899, Doctor R. H. Denney and Canadian born Miss Lillian Nichols were married in Denver, where she had lived since she was a small child. Her parents moved from Montreal where her father had worked for the Canadian Pacific railroad in the shops, and obtained similar employment in Denver with the Denver and Rio Grande Railroad.

Dr. and Mrs. Denney first lived in a rented house in the east part of Elbert, buying the lots where they now live at the turn of the century. The Memorial Day flood in 1935 badly damaged the old house and the new dwelling was completed in December, 1936.

Probably the most strenuous year in the Denney's 60 in Elbert was 1918, the year of the flu epidemic. Doctor was up and started on his rounds by six in the morning, and seldom arrived back home before midnight. Mrs. Denney listed the calls as they came in and Doctor would take them in order the next day, and often calls were relayed to him if he could be reached while on his rounds. During the five or six weeks when the epidemic was at its worst, Doctor would start his rounds East to the Fondis community, then to Bijou Basin, over to Eastonville area, then to the Table Rock community, then back to Elbert by whichever devious route would take him past the homes needing his assistance. Many stops along the way were unscheduled as those needing care would stop Doctor's Dodge as he came along. Not only his own community needed his help; Doctor Rogers at Kiowa had a siege of flu and later Doctor and Mrs. Witter at Elizabeth were both down at the same time with flu and pneumonia, and this meant trips into these communities to see them and their patients. Miraculously, Doctor Denney and his family escaped having the flu.

Nearly every means of transportation has been used by Doctor Denney in making his rounds except



Except for magazines on the table, Dr. Denney's office remained the same as when it was last open to patients, over 30 years before.

by air. He has gone by buggy, by cutter, by bobsled, wagon and on horseback, and in later years by car, by truck and by pickup. One emergency trip, when roads were blocked by snow, was made lying prone on top of a Caterpillar tractor and wondering how long he could hang on as the tractor climbed the steep drifts and pitched down the slopes. He arrived at the call but minus most of his fingernails. Many times it took a relay of horses to reach a call. After the 1913 December blizzard Doctor was called to South Cherry Creek on a pneumonia case. He left Elbert riding his own horse, played him out by the time he reached Tom Cantrill's, borrowed a horse there and played that one out at Royston's; he borrowed another horse and arrived at the case by nightfall. He stayed overnight and made the journey home the next evening.

On another call to the South Elbert County line, and after a heavy snow in late April, he started out with his own team and buggy; he had to replace his team at Cornforth's with a team of mules, then borrow another team at Menburn's in order to reach his case.



Certificate of Membership

1950

The Colorado State Medical Society

This is to certify that

Robert H. Denney M. D.

is a member of

The Colorado State Medical Society
and of
THE AMERICAN MEDICAL ASSOCIATION
for the current year

Fred A Humphrey M.D. President

Harry J. Bartman Executive Secretary

In 1914 Doctor "converted" to gasoline power with his first car, a Model "T" Ford. After the Ford he bought his first Dodge and has owned one since.

How many babies did he bring into the world? Doctor does not know as the 1935 flood carried all his records down the creek, but his "babies" drop by to visit him when in Elbert. Many still live in the community and Doctor has attended the birth of their children. 1946 marked 50 years of practice of medicine for Doctor Denney and the Colorado State Medical Society honored him with the "50-Year" pin.

Doctor and Mrs. Denney have been enthusiastic fishermen all their lives, and Doctor still enjoys the sport; he has done a lot of duck and rabbit hunting and also some deer hunting through the years. Mrs. Denney's interests are her home, her church, and her family and community. Doctor's interests are his profession, his garden, his family, and fishing and hunting. He has always read extensively, keeping up with his medical journals and other periodicals.

Many attractive offers came through the years to establish a practice in the cities, but there were greater inducements other than monetary success that weighed the balance in favor of the country practice of medicine. The tribute to this fine couple in the cards and notes marking their 60 years together in Elbert is indicative of their success in their community, and this wonderful tribute has truly warmed their hearts.



33 years of examinations and remedies delivered in this room, and 27 years of caregiving in his previous home, Dr. Denney saw and attend to much of life in Elbert and Kiowa Counties. The house was opened in 1996 and the room was just as it appears, as if the office had just closed yesterday.

* *By Mrs. B. Laren Gleason, the daughter of Dr. & Mrs. R. H. Denney.*

Out of prescription pads?

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Denver, CO 80210
(303) 555-5555
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Member of the Colorado Medical Society

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Signature: _____
John Smith, M.D.

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o order your Rx pads, please fill out the form below with your information and return it to: Colorado Medical Society, O. Box 17550, Denver, CO 80217-0550, ATTN: Member Services Dept. We **CANNOT customize** the printing of escription pads. They will be in the same form and content as the sample shown here. Payment must accompany der. Make checks payable to Colorado Medical Society. Questions: call (720) 859-1001 or 1-800-654-5653. Ask for e Communications Office.

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PLAIN PAPER PADS

❑ 10 pads for $9.25 ❑ 20 pads for $16.25 ❑ 30 pads for $22.95 ❑ Other (please call for prices)

NCR SETS

(These are not padded. Sets include white original plus a pink second-sheet.)

❑ 1000 sets for $31.20 ❑ 2000 sets for $62.40 ❑ 3000 sets for $93.60 ❑ Other (please call for prices)

Order today and let your patients know that you are a proud member of the Colorado Medical Society.

COLORADO MEDICAL SOCIETY

"Advocating excellence in the profession of medicine"

To my fellow CMS members;

I am writing this letter to draw your attention to the PBS program series, ***"On Our Own Terms: Moyers on Dying in America"***. I believe this four-part series, beginning September 10, 2000, is extremely important because it will engender discussion and education among the public at large regarding end of life issues.

Discussion and education are necessary in order to change the public perception of death and end of life. Many people have an "ER" mentality about end of life care, thinking that everything can and should always be done to remedy the ills of the person, no matter what the age or condition of the patient. This perception must be changed for the good of everyone. As Moyers says, "There can be choices that let us connect what we have valued in our life to the nature of our dying". But how can we achieve this goal?

We, at CMS, have taken great pains in the past few years to broaden our thoughts and discussions around end of life care and palliative care issues. Bill Moyers' series of four programs deals with these issues, philosophically, realistically and humanely.

I strongly encourage you, the physician having to deal with these issues in your practice, to inform your patients of the program series and to watch the programs yourself. It is extremely important that hospice, end-of-life and palliative care be discussed by the public and physicians as well, and that death at last be considered as the final part of life.

Sincerely,

Jack L. Berry, MD
President, 1999-2000

7351 Lowry Boulevard, Denver,CO 80230-6902 • P.O. Box 17550, Denver, CO 80217-0550
(720) 859-1001 or 1-800-654-5653 • FAX (720) 859-7509 • CMS web page www.cms.org

On Our Own Terms

Moyers on Dying



A major PBS series from Bill Moyers premieres September 10-13, 2000, 8-9:30 p.m. on Rocky Mountain PBS.

Based on two years of research and production, this four-part series takes Bill Moyers to the front lines of the movement to improve end-of-life care. Moyers documents remarkable personal stories of the dying as they struggle to live their final days and to come to terms with their life and death.

PROGRAM I: Living with Dying focuses on people - patients and caregivers who are searching for ways to recognize and talk about dying as more than a medical event. It is a part of life that each individual, in every American community, approaches with different attitudes, beliefs and wishes.

PROGRAM II: A Different Kind of Care
Examines the evolution of a new kind of care commonly referred to as "palliative care." Leaders in this movement emphasize a full spectrum of pain management, symptom relief and support including physical, psychological and spiritual care.

PROGRAM III: A Death of One's Own
To many, dying well means a measure of control over how we die. We fear dying in pain, we fear that too much will be done. This program looks at issues surrounding efforts to control how we die - including physician assisted suicide - and the implications for family, institutions, and communities.

PROGRAM IV: A Time to Change follows crusading individuals who are working to change public policy to improve care of the dying. They are creating models for change that deal with issues including insurance coverage, medical training, and support and relief for families who are shouldering the burden of caregiving when a loved one is dying.

Web Site

The ON OUR OWN TERMS Web Site at www.pbs.org/onourownterms includes a bulletin board, downloadable materials, a list of national organizations participating in the program, and other campaign information.

Questions? Please contact Alison Monaghan at Rocky Mountain PBS (303) 620-5684.

Colorado Medical Society

Foundation

service • outreach • education

Colorado physicians care about patients and demonstrate their commitment to putting patients first.

One of the pronounced goals of the Colorado Medical Society for many years has been to extend health care coverage to as many Colorado citizens as possible with the resources available, given the number of practicing physicians in the state. In March1997, the Colorado Medical Society established the ***CMS Foundation*** to administer and manage programs that seek to improve access to health care and services to improve the health of Coloradans.

The CMS Foundation programs include the ***Colorado Rural Outreach Program (CROP)*** which seeks to strengthen the ability of underserved rural communities to have medical services available within a reasonable distance. While our state is experiencing unprecedented growth, the shortage of physicians in rural areas has put our neighbors at risk. The Colorado Rural Outreach Program is designed to address the problem of delivery of healthcare services in rural Colorado.

Since inception, the CROP program has helped place three physicians into rural Colorado communities and has additionally helped expand medical services in Delta, Haxtun, Cheyenne Wells, Custer County, Del Norte, Lamar, San Luis Valley, Springfield, and Westcliffe.

Through the CMS Foundation, the ***Coalition for the Medically Underserved*** grew out of a one-day conference on Caring for Colorado's Medically Underserved, which was convened by the Colorado Medical Society in March 1997. A Coalition of interested members from health professions, provider organizations, hospitals, clinics, medical care organizations, safety net providers, legislators, foundations, state agencies, insurers, consumers, and business groups are joined together to find ways to implement a more unified and coordinated system for caring for Colorado's medically underserved. The ***Coalition for the Medically Underserved*** vision is that by 2007 all Coloradans will have unimpeded access to affordable, quality care. Colorado will have a system for health care financing and delivery than ensures that there will be no barriers to the receipt of medically necessary care.

The Colorado Medical Society Foundation

Leaving a legacy of caring through programs that improve access to health care for all Coloradans.

Colorado Rural Outreach Program (CROP) Summary - Year To Date

In December, 1998, the first CROP grants were awarded:

- To place the first CROP physician in a rural community, Dr. Jose Hinojosa, now practicing in Haxtun, Colorado;
- In Eads, for a cardiac telemetry unit at Weisbrod Memorial Hospital;
- To the San Luis Valley Area Health Education Center, to enable two high school students who have excelled in mathematics and science to participate in a health careers institute;
- Loan repayment assistance to recruit Dr. Kae Loverink in Delta.

In April, 1999, CROP granted:

- General recruitment support to recruit Dr. Bashir at Rio Grande Hospital in Del Norte;
- Assistance to purchase five crash carts and three defibrillators at VallyWide Health Services in the San Luis Valley;
- Assistance with the purchase of a portable x-ray machine at Keefe Memorial Hospital in Cheyenne Wells;
- Assistance with the purchase of basic medical equipment (pulse oximeter and automatic instrument sterilizer) at Custer County Medical Clinic in Westcliffe;
- General recruitment support for Southeastern Colorado Hospital in Springfield, and;
- Facility enhancement support to High Plains Community Center in Lamar.

Colorado Rural Outreach Program

In June, 2000–CROP granted:

- Recruitment assistance to Keefe Memorial Hospital in Cheyenne Wells;
- Assistance with purchase of medical equipment at Plains Medical Center in Limon;
- Assistance with physician support in Silverton, and;
- Loan repayment assistance for a new physician at Surface Creek Family Practice in Cedaredge.

Colorado Medical Political Action Committee

P. O. Box 17550 • Denver, Colorado 0217-0550 • 720-859-1001

You're too busy practicing medicine to play politics.

Join COMPAC today and become personally involved in the future of health care in Colorado, **without playing politics.** The rest assured the voice of organized medicine will continue to be heard at the state legislature. For information, call (720) 859-1001, or 1-800-654-5653, extension 6327

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◆ *PROFESSIONAL OPPORTUNITIES*

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Ruminations

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

Beauty!

That seems a peculiar exclamation coming from me; however, it has been said many times that "Beauty is in the eye of the beholder." Therefore, anyone would seem qualified to discuss the subject of beauty.

Today, we are looking at only one of these truisms: ***"Beauty is only skin deep."***

Earlier this year I was attracted to an article in the Journal of the Royal Socity of Medicine by Nigel E. Drury*. His essay started with:

> "In the *Illiad*, Homer describes the epic battles of the Trojan war as vast armies sailed across the Aegean to rescue the Spartan queen Helen, said to be the most beautiful woman who ever lived. Many painters have since tried to recapture her image on canvas—but what did she actually look like?
>
> Debate over what constitutes beauty has raged since philosophy began."

Mr. Drury goes on to a study of the next aphorism, ***"Beauty is the gift of God."*** He says that ". . .perhaps the most famous illustration is Leonardo da Vinci's drawing of the Vitruvian man, relating the divine proportion to human anatomy—a universal phenomenon uninfluenced by race, age, sex or geographical and cultural factors. All human beings should have the genetic potential to attain these proportions." He further states that "Development towards the divine proportion is therefore a visible reflection of health and survival advantage."

While Drury's essay points out that the age-old law of ***'survival of the fittest'*** holds true in the majority of cases, ***'survival of the prettiest'*** might well be added to the guidelines of life. As Mr. Drury puts it, "The natural variation within a species creates a range of phenotypes and thus a rank of survival advantage, with some better adapted to attract a partner than others, ***'survival of the prettiest'***. From an evolutionary aspect, function always precedes form. If the genetic objective of life is to mate with the best available partner, any features promoting the owner's genome will be a favorable investment."

Drury puts it well when he said, "In human sexual seletion, males and females have different reproductive strategies. A male requires a partner who is receptive, highly fertile and healthy. On the other hand, females can increase their reproductive success by choosing a high-status male who commands resources and can provide material security for her offspring."

He continues, saying "Consequently, rivalry to attract women focuses on acquiring and displaying such assets, as constantly demonstrated by young men. Longitudinal data suggest that physically attractive women tend to marry men of high occupational position. Is this to say that, for some at least, "beauty is only wallet deep?'"

Whatever the case for beauty, skin deep or otherwise, it has been decided that the face is the principal focal point of judging beauty. Drury states, "Babies as young as three months have a marked preference for attractive faces, as defined by adult preferences." Thereby, judgment of facial attractiveness is thought to be an instinctive phenomenon.

Mr. Drury concludes his essay by saying, "beauty is a universal phenomenon, present across man species and all ages. Indeed, the outward reflection of beauty reaches anatomically deeper than bone and evolutionarily beyond the genes. Throughout the higher animal kingdom, reproductive division of labour between the sexes has led to greater success through role specialization. Beauty is a consequence of this process, exploited to demonstrate fecundity and attract a suitable partner. In human beings, it has become a principally male concept of favourable female appearance, not through social conventions but via evolution[1].

Drury adds, "But as 'the snake' put it: 'I'm tired of all this nonsense about beauty being only skin deep. That's deep enough. What do you want—an adorable pancreas?'[2]"

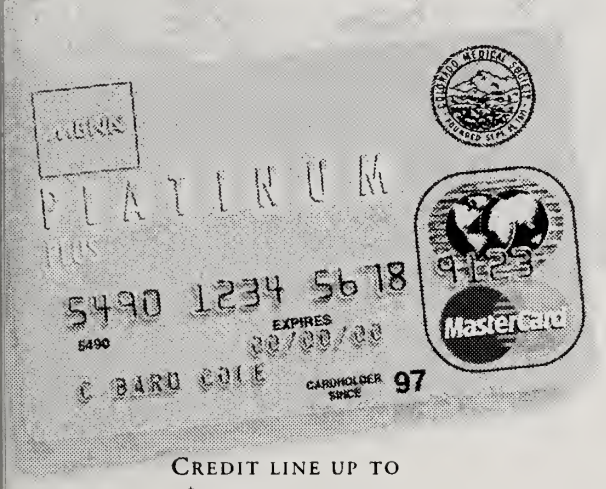
References:

1 Chen AC German C. She is not a beauty even when she smiles; possible evolutionary basis for a relationship between facial attractiveness and hemispheric specialisation. *Neurospychologica*1995;**33**:649-5

2 Kerr J. The Snake has all the lines. In: Augarde T, ed. *Oxford Dictionary of Modern Quotations*. Oxford: Oxford University Press, 1991:120

* J R Soc of Med 2000; **93**: 89-92

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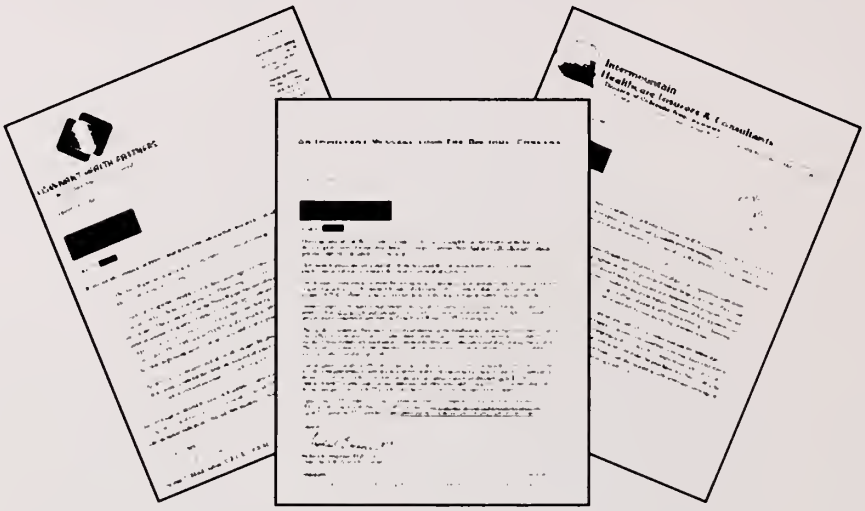
CMS Annual Meeting

The St. Regis Aspen

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A rich legacy and a bright future: Copic by Jerome M. Buckley, MD ..... **page 321**

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COLORADO MEDICINE

September, 2000 **Volume 97, Number 9**



Cover Story

Will 2001 be a medical odyssey? We don't have the answer, but we do introduce our CMS 2000-2001 program year beginning with the Annual Meeting this month.

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO 80230-6902. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Denver, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Jack L. Berry, MD
President, 1999-2000
Colorado Medical Society

I'm using my final article in *Colorado Medicine* to review this past year's Colorado Medical Society accomplishments and program development. I would do so, however, in a somewhat different manner than ordinary by recognizing our outstanding staff and outlining their individual accomplishments toward our CMS goals. We as professional societies far too often fail to recognize our staff persons and give them their due. This can also serve for many of you as an introduction to the staff and define their jobs for you.

First, I want to extol the virtues of Sandi Maloney, our Executive Director. She is responsible for the work of, and has assembled, an extremely functional and loyal staff. She is also responsible for keeping leadership on track and directed appropriately to accomplish our goals. Probably her greatest skill is adapting to a new president and other leaders every year, facilitating each one's particular skills to get needed tasks accomplished to meet CMS goals for the year. This year she accomplished all this despite often not feeling well because of a serious illness, never wavering from her duties, and even, when necessary working from home. Our staff supported her through tough times in every way appropriate; a reflection on Sandi's work over the years to create this staff and her superb personnel management skills.

The Executive Director is supported at the first level by Debbie Jones and Genni Pearman. Genni this last year served Sandi as administrative assistant and showed such initiative in coordinating functions of the executive department and communicating well with leaders and members that she has been asked to move up into Government Relations and work with legislators and other elected and appointed officials. Debbie coordinates our executive department's operations and relationships with the Board of Directors, the House of Delegates and the AMA Delegation. She has helped leadership understand policy, created our board packets, our HOD notebooks. She has collated all the materials necessary for the AMA Delegation to consider and utilize as we function at the national level. The materials have always been complete and accurate despite their astounding volume.

Nan Deter is our accounting manager but really functions as a CFO. She has given Sandi the information necessary to create a sound, positive budget, kept the Finance Committee fully and appropriately informed, and kept the books well so our auditors have been satisfied. She also manages our invested funds according to Finance Committee direction and provides accounting services to the CMS Foundation. All the above is done so well, even we physicians could understand the figures.

Sandy Finney is Director of our Professional Services Department. She coordinates, develops and implements all our meeting programs and facilities. She also staffs the Council on Ethical and Judicial Affairs, particularly challenging this year as we considered a number of controversial ethical issues. Her production of our interim educational meeting titled *Education for Physician in End of Life Care* was particularly well done regarding faculty development and institutional materials. Her work is being exported throughout the state by several component medical societies and is available to anyone for reproduction and extended education.

Don Rutt also works in the Department of Professional Services and is responsible for mailroom and other communication services. The volume of incoming and outgoing communications is prodigious and Don has cared for us here accurately and efficiently.

In the Department of Health Care Finance, as you can imagine, Edie Register and Marilyn Rissmiller have been extraordinarily busy. They serve us on the front lines as we deal with HCFA, managed care entities, physician organizations (IPA's, etc.) and any other body with whom physicians must contract. They staff our Managed Care Task Force, the Workers' Compensation and Personal Injury Committee, and the CMS/HMO Association Joint Committee. They are our advocates in negotiations with any entity affiliated with any of the above. The *Hassle Factor Project* and their development of model contracts have this year given us all ammunition to deal with the myriad of frustrations for physician care and for CMS to use in the legislative fights over managed care abuses.

Chet Seward is director of our Health Care Policy Department and oversees program development as CMS reaches out to members and the public by facilitating systems of health care delivery. He is lead staff for the Colorado Coalition for the Medically Underserved, one of the CMS Foundation's most visible and credible programs. He also staffs CMS' Accountability and Joint Data Committees.

In Chet's department are Suzi Shevell and Lorraine Heth, Program Managers, and Anita Wesley, Program Assistant. Anita assists Chet with Coalition duties and also assists the CMS Foundation Director with other activities. Suzi staffs the Rural Health Task Force and was instrumental in developing the information supporting CMS's rural health efforts in service and legislation. She also staffed the Task Force on Gun Related Mass Assaults which produced an excellent report for the House of Delegates. It will be useful to all others working with these issues across the state. Lorraine works diligently with the CMS Committee on CME Accreditation and the Medical Informatics Committee. She was very instrumental in development of our annual meeting program last year on medical informatics.

Anita Albrecht serves as the director of the CMS Foundation and has brought it to the status of a well known and respected statewide philanthropic foundation. Her organizational and grant writing skills have resulted in our obtaining many gifts and grants over the last year. The most notable is a grant from the Colorado Trust of $1 million to the Colorado Rural Outreach Program (CROP) over the next three years. As a result of Anita Albrecht's, Anita Wesley's and Chet's efforts, the Coalition also received a grant from the Colorado Trust for $650,000

Tim Roberts, Beth Crusha and Mary Lee Johnston have worked in the Membership and Information Services Department to maintain and even slightly increase CMS membership even in the face of times that have seen decreasing membership in other state societies and the AMA. Tim is the director of this department. His greatest accomplishment this last year was in implementing the smooth transition of all our information and computer systems during our move. This allowed a virtually seamless and glitch-free continuation of service to all of you, our members.

Suzanne Hamilton replaced Lorrained Koehn as director of our Department of Governmental Relations and we are indeed fortunate to have her fill Lorraines very large shoes. Suzanne very simply conducted the most effective legislative campaigns I witnessed by any entity this year at the State Capitol. This is witnessed by a 98% success rate in favorable outcomes with CMS legislative issues. Most notably and important to me and all rural physicians was passage of HB 1063 granting tax credits to rural physicians for educational loan repayment after 6 years of effort toward this end. Suzanne works extraordinarily effectively with our lobbyist, Jerry Johnson, in the electoral and the legislative processes representing all of Colorado medicine in the most credible manner.

Bill Pierson is easily known to all of you as the longtime voice of Colorado medicine in sound and print. He is the publisher of your journal, Colorado Medicine and is our first and primary media contact. Our journal ranks highly in comparison to other state society journals. His work in journalism has been exemplary; his column "Ruminations" is always thought provoking and entertaining. We as a society and as individual physicians owe much to Bill. He will " probably" retire some year soon and when he does we will miss him greatly. We can feel fortunate his son Brad, an artist and designer, has ably assisted Bill in Communications and Member Benefits work this year. Bill may be "grooming" his son to take his place.

As you can see we have an extraordinary staff. I am thankful to CMS membership for having honored me with the opportunity to work with them. Together we have accomplished much and you can count on them to accomplish much more for Colorado's physicians in years to come.

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The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

CMS Med Fax®

. . . a compilation of medically-related news briefs of immediate interest to the physician community occurring after COLORADO MEDICINE has gone to press. **AT PRESS TIME . . .**

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Two New Supreme Court Abortion Cases

By Robert Spencer
Shareholder
Montgomery Little & McGrew, P.C.

On June 28, 2000, the United States Supreme Court handed down two new decisions supportive of a woman's right to abortion; one striking down Nebraska's "partial birth abortion" ban; and the other upholding Colorado's "8-foot zone law."

Stenberg v. Carhart

Nebraska law prohibited "partial birth abortions" unless the procedure was necessary to save the mother's life. Violation of the law was a felony and grounds for automatic revocation of a physician's license. Partial birth abortion was defined as a procedure wherein the doctor "partially delivers vaginally a living unborn child before killing the . . . child," and further defined "partially delivers" as "intentionally delivering into the vagina a living unborn child, or a substantial portion thereof." The intention of the statute was apparently to specifically ban the procedure known as "dilation and extraction," or D&X, whereby the torso of the fetus is delivered into the vagina prior to dissection.

Dr. Carhart, a Nebraska physician who performs abortions, sought judicial review of the statute, seeking to have it declared unconstitutional. He was supported in his effort by the American College of Obstetricians and Gynecologists, which filed an *amicus* brief. Nebraska State Attorney General Stenberg sought to uphold the statute, and was supported by *amicus* Association of American Physicians and Surgeons.

Prior law, beginning with *Roe v. Wade*, held that a woman has the right to terminate pregnancy before viability. Post-viability, the state may regulate and even prohibit abortion except where "necessary, in appropriate medical judgment, for the preservation of the [mother's] life or health." The Court found the Nebraska law deficient in that although it permitted partial birth abortion when necessary to save the mother's life, it failed to make the necessary exception for the preservation of the mother's health. The State argued that the exception was not required because a D&X procedure was never necessary to preserve the mother's life given the availability of alternate procedures, such as dilation and extraction (D&E). The Court noted, however, that the *amici* had differing opinions on this point. Although AAPS agreed that the D&X procedure was unnecessary, ACOG disagreed, claiming that in certain circumstances the D&X procedure was safer and carried less risk of injury to the mother's uterus and cervix. In the absence of controlled clinical studies proving one procedure was safer than another, the Court was reluctant to say that the D&X was never indicated to preserve the mother's health. This was a decision appropriate for informed medical judgment, and therefore an exception permitting its use to preserve the mother's health was required.

The Court also held that the Nebraska law places an undue burden upon the woman's right to an abortion in the second term. Prior to viability, the state may regulate the place and manner of abortion, but may not enact a law that places a substantial obstacle in the woman's path.

(continued on next page)

CMS Med Fax

The Court found, however, that although the law might be aimed at the controversial D&X procedure, its plain language also reached the D&E procedure which, according to expert testimony, is the most common procedure performed in the second trimester. The Court held that because the D&E often involves extraction of an arm or leg into the vagina prior to dissection, it too was subject to the law's ban on delivery of a "substantial portion" of the fetus. By also reaching D&E's, the law unduly burdens the woman's right to access to a safe and efficient procedure.

The Court's ruling does not appear to bar every law banning partial birth abortions, but only those that sweep too broadly upon the woman's right. The Court's ruling suggests that a law banning D&X procedures could pass constitutional muster if it provided an exception to preserve the health of the mother, and was carefully crafted so that it did not also ban the more common and less controversial D&E procedure. Given the limits of the Court's decision, I suspect we have not seen the last of partial birth abortion legislation.

Hill v. Colorado

Colorado Revised Statute §18-9-122(3) makes it unlawful for any person, within 100 feet of a health care facility's entrance, to knowingly approach within 8 feet of another person without consent to pass out handbills, display a sign, or orally counsel or protest the passerby. The Court sustained this law against constitutional challenge because it's restrictions were content neutral and were narrowly tailored to serve a significant government interest.

The Court recognized the competing interests at stake. On the one hand, a protester's First Amendment rights are clear and undisputed. On the other hand, the state has a legitimate interest in protecting the safety of its citizens and assuring access to health facilities. The balancing of one person's privacy interests in being "let alone" had to be balanced carefully against a speaker's right to freely communicate.

In striking that balance, the Court was impressed that the statute did not limit the content of speech, nor did it prohibit a protester from approaching a willing listener. Instead, it served only to protect passersby from unwanted communication. Even then, the Court noted, the 8-foot zone was a "normal conversational distance" would have little impact upon a reader's ability to read a sign or hear a speaker.

The Court rejected the argument that the statute served only to infringe the rights of abortion protesters, and therefore was not content neutral. The Court noted that the statute applied to all demonstrators, regardless of issue and regardless of orientation. Furthermore, it did not restrict at all the content of the speech, but only placed minor restrictions upon the location of that speech. The law appropriately respected the protestors' First Amendment interests because "absolutely no channel of communication is foreclosed. No speaker is silenced. An no message is prohibited."

The Colorado legislature is to be commended for tailoring a statute narrowly enough to pass the Supreme Court's scrutiny. Our legislation will likely become a model for other states to follow.

"Healthy Colorado Now" Initiative Announced

The Colorado Coaliton for the Medically Underserved (CCMU), consisting of over 150 organizations and individuals, announced its statewide effort to achieve affordable health insurance for all Coloradans by the year 2007.

At a news conference held at the headquarters of the Colorado Trust August 15th, the Coalition officers announced the "Healthy Colorado Now Initiative" has already launched this statwide effort, commencing with a series of town meetings. The first meetings were held August 22nd in the Denver Metro area. Other meetings will be held across the state in coming weeks and months.

Town Hall attendees will be asked to respond to five possible approaches to achieving health insuranace coverage for every Coloradan. After almost a year's study and research, CCMU designed the five models . "Each option has elements recommending it," said Gary VanderArk, MD, chairman of CCMU. "There is no approach that is clearly superior and hybrids are not only possible, but likelyto result from the feedback we receive at the town hall meetings."

CCMU research indicates there are nearly 580,000 Coloradans currently without health insurance, roughly 15 percent of the state's population. Another 12 percent are estimated to be underinsured.

CCMU was the result of a one-day conference on caring sponsered by the Colorado Medical Society in1997. From this the Coalition grew, born of a desire to implement a more unified and coordinated system for caring for Colorado's medically underserved. The Coalition is now a program of the Colorado Medical Society Foundation.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Colorado Dermatological Society Annual Meeting
September 8-9, 2000
Denver, Colorado
St. Joseph's Hospital
Contact: (303) 770-6048

GMP/Quality System Requirements & Industry Practice
September 11-15, 2000
Denver, Colorado
Contact: (800) 332-2264 x 260

Update on Infectious Diseases in Primary Care
September 16, 2000
The Antler Adam's Mark
Colorado Springs, Colorado
Contact: (303) 372-9065

Level II Physician's Re-accreditation Seminar
September 22-23, 2000
Embassy Suites-DIA
Denver, Colorado
Contact: (303) 575-8763

Risky Practices- An HR Workshop
September 28, 2000
Northern Colorado Medical Center
Greeley, Colorado
Contact: (720) 858-6178

The Palliative Care Certification Course
October 1-6, 2000
Westin Crowne Center
Kansas City, Kansas
Contact: (316) 263-6380

Lawsuit Stress Support Seminars
October 5, 2000
Copic Insurance Company
Denver, Colorado
Contact: Pat Schultz (720) 858-6055

20th Annual Big Sky Pulmonary & Critical Care Medicine Conference
March 21-24, 2001
Big Sky Ski Resort
Big Sky, Monatana
Contact: (406) 442-6556

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

THE CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance

The ***CMS Office Manager*** is a genuine Medical Office Resource.

CMS publishes a bimonthly newsletter dedicated to providing the physician's office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on staff analysis of the problems facing the physician's offices. The newsletter is free to the office staff of CMS members, Non members can subscribe to the newsletter at a cost of $75.00 per year.

If you are currently not receiving the newsletter in your office, please copy this form, complete it and fax it to Marilyn Rissmiller at (720) 859-7509, or mail it to P.O. Box 17550, Denver, CO 80217-0550.

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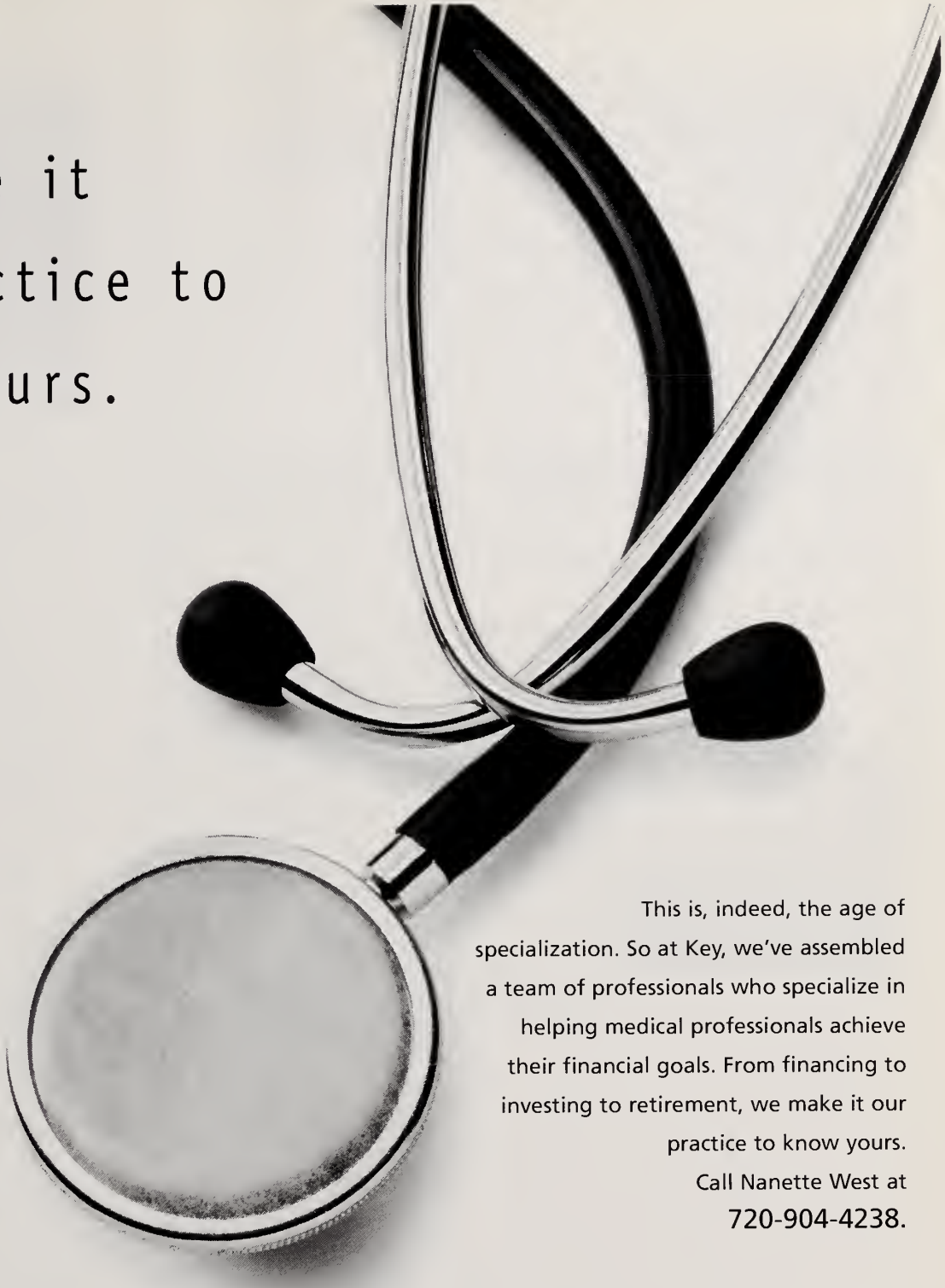
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The web sight
of the
Colorado Coalition for the Medically Underserved
is now in operation.
Check it out at
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Who's WATCHING OUT For You?

From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovate solutions to complex dilemmas.

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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

The CMS Annual Meeting this month in Aspen may prove to be one of the most benign meetings on record. Of course, I think I say that every year about the time I am writing this, because the number of resolutions that have been submitted seems small, and the nature of the subjects also look tame. We still have the late resolutions to look forward to, but I haven't heard any great rumblings out in the hustings that would indicate we're going to have a big issue pop up.

It's that kind of review that gets you in trouble, because as sure as you say it, the reverse is suddenly true. I'll never forget that one year (not so long ago) that the issue of smoking in the CMS offices came up on a resolution asking for the outlawing of smoking in, on or around CMS offices. The Reference Committee ran very late because of the issue, and then the discussion on the floor of the House went on interminably. It was an issue which no one expected to cause much discussion. That was one of those years when we didn't expect anything unusual to happen.

In 2000, as you will see by the Resumé, there's a wide variety of subjects. I am happy to say, the majority of the issues deal with the improvement of health care. I am certain, however, that the issue of gun control will come up, since we have at least three resolutions concerning children and guns. If we get sidetracked onto the highly emotional subject of gun control, the House may have to stretch itself.

The number of resolutions submitted seems to be a little above average. There's nothing much which **seems** as though it should require a lot of discussion. That's as far as I will go making any kind of forecast.

On the subject of violence, guns, assault and the like, there are three separate resolutions somewhat interconnected. These are obviously important issues to a lot of doctors. It brings to mind a different kind of approach to the subject of violence-related injuries which one physician has taken. Dr. Roderic (Rod) Gottula of Aurora-Adams County Medical Society is experienced as a Colorado Criminal Justice System physician. He is a Family Practice physician who has seen the effects of prison incarceration on both the prisoner and the prisoner's families. Gottula feels strongly that families are suffering for want of social programs which cannot be funded because of the cost of locking up offenders. As he points out, we are willing to spend $25 to $30 thousand a year to keep one person in the slammer, while other social programs go begging for money.

Dr. Gottula introduces his collections of notes and observations on the criminal justice system, saying, "In the year 2000, the United States set a record for the unenviable position of having two million of its citizens locked behind bars. The cost to the taxpayers for this achievement is one hundred million dollars per day." Well! Those two figures alone are something to think about. When you multiply the 2 million by, let's say, 500,000 spouses and an average of 2.3 children per family, those lockups impact a lot of people.

Res-16-P, "Endorsement of the Voter Initiative to Close the Gun Show Loophole",

Res-17-P, "Task Force to Study Violence Related Issues", and

Res-18-P "Report on Recommendations from the Gun Related Mass Assault Task Force".

Roughly 12% of those people incarcerated in the U. S. are mentally ill, of which about 50% were unemployed (and probably unemployable) when they were sent to prison.

Is there a better way? Can we do anything to help in this situation? The three resolutions mentioned here, plus the task force and committee work which brought them forward, are positive steps. They are attempting to treat the cause rather than wrestle with the effect. I applaud Dr. Gottula's efforts and want to help him educate people to this huge problem. I think, without question, the issues before the House of Delegates this month are anything but lightweight or "business-as-usual" issues. There may not be a lot of discussion during this session, but the outcome can be hugely significant. See you there!

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COLORADO MEDICAL SOCIETY ALLIANCE
FALL MEETING

St. Regis Hotel, Aspen
September 21-23, 2000

The Alliance fall meeting is shaping up to be an exciting one in 2000. The St. Regis is a gracious setting for our special time together. We will use a 1950s theme to celebrate the fiftieth anniversary of the AMA Foundation. Come prepared to enjoy it by wearing your favorite '50s style clothes at the Thursday dinner board meeting and at the general meeting on Friday as well. Use your memory or your imagination and join the fun.

We will have two special speakers. As always, an AMA Alliance speaker will join us. This year's speaker will be Mrs. Barbara Jett, one of the AMA Alliance Field Directors who will speak on leadership and membership in your alliance year.

Our second guest speaker will be Mr. Jim Hillhouse from Copic who will speak on ***The ABCs of Retirement Planning for Spouses- Minimizing Mistakes-Maximizing Fulfillment of Your Dreams and Aspirations.*** Jim is Copic's SEC Registered Investment Advisor and is experienced in managing investments. He will leave fifteen minutes for questions, so be sure to have them ready.

CMS ALLIANCE FALL MEETING 2000
REGISTRATION FORM

Registration fee: $25 per person ..... $_____

Thursday, September 21
6:00 p.m. Highlands Room
Dinner and board meeting (including county presidents) $39.00 ..... $_____

Friday, September 22
8:30 to 9:15 a.m. (Room to be announced)
Continental breakfast (No charge, but must rsvp) ..... _____

9:15 to 12:00p.m. (Room to be announced)
2:00 to 5:00p.m. General meeting and workshop ..... _____

Saturday, September 23
Morning- casual get together: No charge

Total: registration and meal (if applicable) ..... $_____

Your check is your reservation. Mail to Donna Foss 1675 S. Fairfax St., Denver 80222

Letters

To the editor:

Recently I attended a seminar regarding the patient's viewpoint of various aspects of medicine. This was a well organized, well attended and well-funded, one-day symposium. Although there were very few (maybe 6-8) physicians present , the majority of the audience of about 350 people was made up of representatives of various patient groups and patient advocates.

It was obvious from the outset that the majority of the attendees were well-versed in internet communication and information retrieval. Many of them spoke very eloquently putting forth the causes of their own specific interest; however, there was a fair amount of "doctor-bashing" scattered throughout the day. One patient advocate speaking from the standpoint of her problems with hypertrophic cardiomyopathy stated that she had visited a group of "fourth year cardiology students" and that "she was the first patient that they had encountered during their medical training". I found this difficult to take on face value and stated to the audience that most medical schools (certainly UCHSC) have medical students seeing patients from the first week of their training and all the way through their medical education.

This experience has led me to reflect upon certain terms that we use every day and perhaps without much thought. The term that comes to mind is "Patient Empowerment". I think that this is a bad term just as much as is the term "Physician Empowerment". Unfortunately, many patients feel "empowered" if they search for information on the internet and, unfortunately, there is a great deal of bad information along with the good to be had from this particular source. By the same token, I dislike the term "Physician Empowerment" because this carries the connotation of a person that is "superior", "aloof", or even "unapproachable". I think that far better terms would be "Informed Patient/ Receptive Physician". The days whereby the physician can be autonomously placed on a pedestal have long since gone. Nowadays the physician should be perfectly willing to discuss with patients any aspect of their disease process. For that reason, an informed patient is one who will probably have a better grasp or understanding of what he/ she is being told and can certainly ask more intelligent questions. I welcome the opportunity to discuss with patients and their close ones any aspect of their disease process that seems to be of concern to them.

I would propose that we relegate the term " Empowerment " to the darkest corner of the darkest closet and let it stay there.

W. Gerald Rainer, M.D., F.A.C.S.
Denver

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Fall Clinics
of Montrose, Colorado

Over 100 physicians from Colorado and several neighboring states will gather in Montrose to participate in the 29th Annual Montrose Fall Clinics on September 29 and 30, 2000. The Fall Clinics are sponsored by the Montrose Memorial Hospital and its medical staff.

Guest speakers will present various medical topics during the meetings, which will be held at the Montrose Pavilion, 1800 Pavilion Drive.

Registration will begin at 8:00 a.m. on Friday, September 29, with lectures throughout the day, and from 8:30 a.m. through 12:30 p.m. on Saturday, September 30.

Scheduled to speak at this clinic are:

- **Bahri Bilir, M.D.**, Medical Director, Centura-Porter Liver Transplant Program, Clinical Gastroenterologist, Arapahoe Gastroenterology, Denver, Colorado
- **Glen M. Bowen, M.D.**, Associate Professor, Department of Dermatology, University of Utah, Salt Lake City, Utah
- **Richard C. Fisher, M.D.**, Associate Professor and Practice Director, Department of Orthopedics, University of Colorado, Denver, Colorado
- **Javier F. Magrina, M.D.**, Professor and Chairman, Department of Obstetrics and Gynecology, Mayo Clinic, Scottsdale, Arizona
- **Steve H. Parker, M.D.**, Assistant Clinical Professor, Department of Radiology, University of Colorado Health Sciences Center, Medical Director, The Sally Jobe Breast Centre, Denver, Colorado
- **C. William Schwab, M.D.**, Professor of Surgery, Chief, Division of Traumatology and Surgical Care, University of Pennsylvania Health Systems, Philadelphia, Pennsylvania

Topics discussed at the Clinic will be:

- ABC's of Hepatitis
- Complications of Liver Cirrhosis
- The Diagnosis and Management of Pigmented Lesions and Melanoma
- Dermatological Look-Alikes and Their Pitfalls
- Developing World Medicine and the Fear of Big Numbers
- The Management of the Atypical Pap Smear
- Office Management of Ovarian Cysts
- Minimally Invasive Breast Biopsy
- Breast Ultrasound Pathology
- Violence in America: Medical Aspects
- Injury Amongst Our Elders

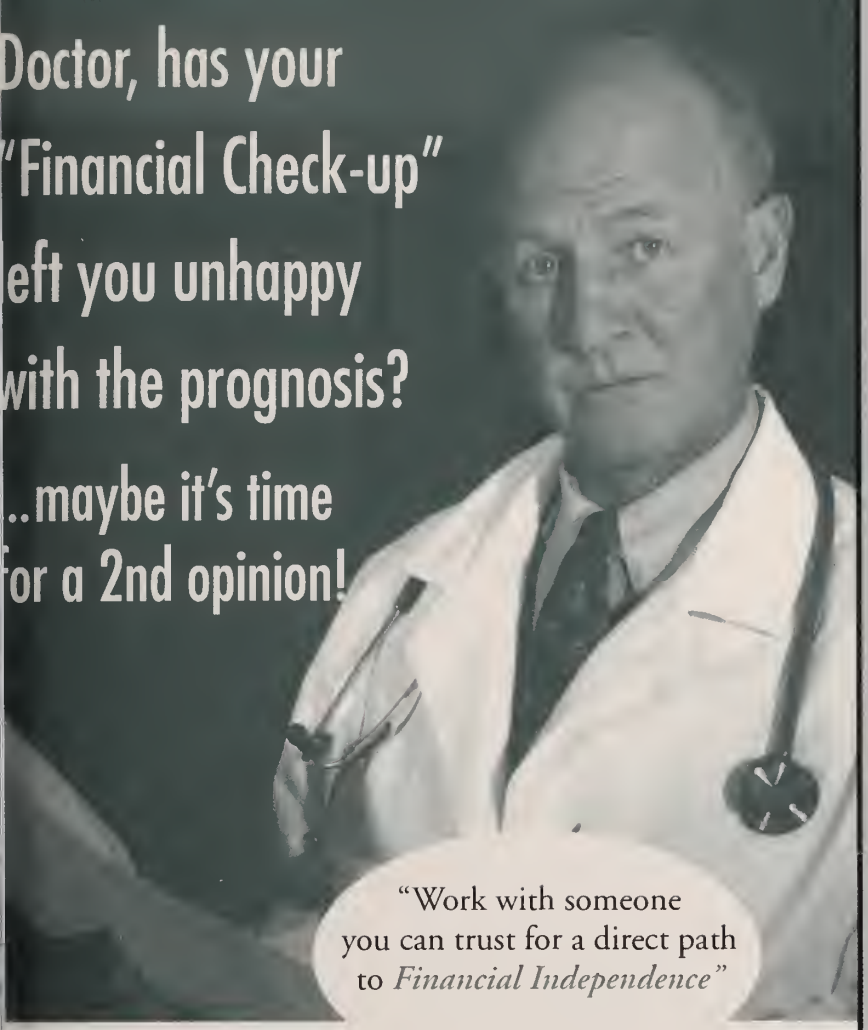
The participants as well as the guest: speakers will discuss interesting case presentations at the end of Saturday's program.

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Eleven hours of Category I AMA credit will be given to those attending this Clinic.

The Annual Fall Clinics Awards Banquet and dance will also be held at the Pavilion on Friday evening. Entertainment will be provided by Rick Marshall, "The Coach", and dancing will follow the entertainment. The post conference retreat will include a barbecue at The Inn at Arrowhead.

Persons who would like further information on the clinic may contact Kathy Holman at the hospital, 970-240-7397.



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John L. Lightburn, M.D.
Historian
Colorado Medical Society

The '60s. . . A Decade of Turmoil!

Continuing our saga through the Twentieth Century, we come to a decade of enormous change. In medicine, scientific advances dramatically changed how all of us cared for our patients. Looking back, those years seemed to be the best of times. We remember our work in the office and hospital with a yearning nostalgia. We were in charge; no need for prior authorization from a managed care clerk. But when we pause to look more closely at the sixties, exquisitely painful memories invade our consciousness. The sixties were miserable. We were involved in a emotionally and physically depleting war that went on and on and on. There were race riots, church bombings and murders; there were student protests and marches on the Capitol. And there were assassinations. The very fabric of our civil society was coming apart. With that brief background note, here is how our CMS presidents functioned in those difficult times.

John L. McDonald, a Colorado Springs cardiologist, was our 90th President, 1959-60. When elected, he questioned his own suitability for the position. Some members of the House of Delegates also questioned his suitability. "He was too left wing." A majority of the House respected his honesty and leadership and elected him by a narrow margin. During his presidency, his grasp of history and his practical understanding of the current economic and social realities enabled him to accurately predict the changes that the profession was to experience, changes that are still taking place today. In his Presidential address, he foresaw medicine moderating its inflexible opposition to closed-panel practice; he told his listeners that a system very much like present day Medicare was inevitable, and he urged his colleagues to guide the development rather than stubbornly oppose its creation. "I don't buy the 'Customer is always right' slogan, but.... history proves that when enough customers, en masse, demand a change, they get it." This was not a popular position. During his year as president, the House of Delegates disagreed with him often. He accepted their position and collaborated with the House to effect important changes in the organization of the society. Less than a year after he completed his presidency, he succumbed to complications of hepatitis.



John L. McDonald, M.D.

Those who had feared that John McDonald would be too liberal, equally feared that our next president, Cyrus W. Anderson, would be too "right wing". But when Cy Anderson became President-elect under President John McDonald, they worked well together as they reorganized the cumbersome committee structure of the society and persuaded the House to authorize a CMS home office building.



Cyrus W. Anderson, M.D.

Cy Anderson, this Denver born son of Swedish immigrants, was a true believer in the American free enterprise system and was alarmed at the country's drift toward socialism. He had been president of the

Association of American Physicians and Surgeons, organized because its members thought the AMA was too liberal and not effective in its opposition to "socialized medicine". He fought to the bitter end against any and all government involvement in private medical practice.

Cy's Presidential address was an eloquent call for all physicians to save the country from the evils of the foreign ideologies of socialism and communism. "The 1960 Democratic platform reads almost identically to the platform ...of Norman Thomas' Socialist Party of 1928 and the Republican platform is only slightly less undesirable." He described how the 'welfare state' was creating an immoral society, encouraging thievery and sloth. But he said our representatives were not completely at fault. They were too busy to understand what was happening and were led astray by the intellectuals and professors who had descended on Washington and were leading our representatives down the wrong path. He described in detail how the communists had successfully confused the American public about the meanings of the words "liberty" and "conservative" and "liberal". "Many Americans have become alienated from the inner principles of the republic. . . . . The medical profession is the last great bastion of freedom in the United States. It is the one great nucleus from which a reversal of this trend could spring. The socializers are well aware of this and will be relentless in their efforts to slap on more government controls . . .Can you think of any other organization of almost 200,000 well educated men with the advantage of daily personal contact with millions of people:, People will lend an eager ear . . . I sincerely urge you all to make use of this potential. . . . Become active in politics in every way that you can ....Take a few extra minutes with each patient talking economics, Americanism, anticommunism. Include in your monthly statement a paragraph . . . . that you like the American free enterprise system which has far surpassed those of every other country. . . Talk, talk, talk. Arrange friendly meetings with your Senator. Never refuse to speak to your P.T.A., your Church group . . . Let's make use of our political strength."

Yes, Cy was a dreamer, an idealist, but his dream to defeat the Federal Government's plan to become involved in health care was never realized. Yet, he dreamed of a more efficient and responsive medical society, and he helped build one. And he dreamed of a beautiful summer home in the mountains, and he built one mostly with his own hands. How painful it must have been for him to witness the events of the next ten years.



Vetalis V. Anderson, M.D.

V. V. (Vic) Anderson, our 92nd President, 1961-62, was a general practitioner from Del Norte. He grew up in the mining camp of Victor, Colorado. He earned his way through both college and medical school by working summers as a hard rock miner in Cripple Creek, and a tire molder for Gates Rubber Co. during the school year. Following his internship, he set up practice in Del Norte in 1937. Three years later he was on his way to the Philippines as a medical officer for the New Mexico National Guard, an assignment that lasted five years and almost cost him his life. He was not in the Philippines long before the Japanese attacked and he became a part of the infamous Bataan Death March. He survived three death sentences imposed on him by Japanese courts martial. He twice received a temporary reprieve because he was the only doctor in the prison camp and once because he was needed to cut and carry 300 pound loads of ironwood for his captors. He survived this terror while many succumbed. He then watched hundreds of friends go to their death as U.S. bombers destroyed Japanese troop ships starting on a journey back to Japan loaded with American POWs. Restored to the U.S., he spent several months in the hospital recovering from beriberi and malnutrition. After several months of postgraduate studies he returned to Del Norte, a war hero, where he became the leading doctor and the leading citizen of the entire San Luis valley. He delivered a powerful Presidential address urging his colleagues to engage in every possible civic activity. He was an heroic man and gave the CMS an inspiring administration. He died five years after his presidency of kidney failure, probably the result of his war time experiences.

Our 93rd President, Bradford J. Murphy*, was a Denver psychiatrist. An urbane, worldly man, he immediately impressed you with his dignified demeanor and verbal facility (not at all like his rough hewn predecessor, Vic Anderson). Brad Murphy's articles on the dangers of Federalized medical care and the Social Security system appeared frequently in medical journals. He was a gifted and entertaining speaker.



Bradford J. Murphy, M.D.

He was, simultaneously, a quietly efficient President of both CMS and the Denver Rotary Club while following numerous other civic pursuits and a heavy psychiatric practice - all while becoming increasingly blind from rapidly developing cataracts. His secretary, wife and hospital nurses had to read to him, take him on hospital rounds and show him where to enter and sign orders and progress notes. Finally, when all was running smoothly at CMS, he took the month of July off for cataract extraction. Two months later at the annual meeting of CMS, he appeared ten years younger and was overheard saying, "The skies were never so blue nor the girls so pretty".

Two months after Brad's presidency was completed, an assassin's bullet shattered the skull of President John F. Kennedy. Knowing Brad as I did, I can imagine him saying "Now the country is really going to Hell." Indeed, the turmoil associated with the war in Vietnam was just beginning to spread over the entire United States.

Vernon L. Bolton was our 94th CMS President, 1963-64. His presidency was a quiet, conservative



Vernon L. Bolton , M.D.

administration which belied the whirlwind of activity that filled each day of Vern's life. He started his life in Oklahoma, worked his way through college and medical school in Oklahoma and later Kansas by earning money as a boxing coach and as a professional boxer! Following his internship, he spent two years as a general practitioner in Alamosa before returning to Oklahoma for a radiology residency. But when the Japanese bombed Pearl Harbor, he left the residency to become a medical officer in the Army, eventually becoming a full Colonel commanding a hospital in the South Pacific. After the war, he finished his radiological training and then started practice in Colorado Springs.

What set Vernon Bolton apart from us ordinary mortals was the variety and intensity of his interests and pursuits. He had an active practice, ran an investment company, occupied many offices in medical societies, kept himself in athletic trim and followed a bewildering variety of hobbies. He collected rocks and semiprecious stones, created jewelry, collected native American artifacts, flew his own plane, enjoyed figure skating and skiing, had a horse at home and kept more horses at his ranch and he swam daily. His was the "good life", and it is not recorded what impact the sixties had on his life.

We were living in relative peace in Colorado, while race riots raged in the east and south of our nation and the Viet Cong was getting the upper hand in South Vietnam. The U.S. was about to become totally involved in a very tragic military undertaking.

Samuel B. Childs, Jr. , 95th President, 1964-65, was a "chip off the old block". Father and son both did their undergraduate studies at Yale, both went to medical school in New York City, both were outstanding athletes, both were presidents of the Denver Medical Society and the



Samuel B. Childs, Jr., M.D.

Colorado Medical Society. The father inducted the Society's first Executive Secretary, Harvey Sethman, in 1929 and the son presided over the Annual Meeting in 1965 two weeks before Harvey Sethman retired. The elder Sam Childs left a successful surgical practice in Connecticut to come to Denver in search of a cure for his tuberculosis. Later, he became one of the region's early radiologists. The younger Sam Childs was a successful Denver surgeon. At six feet, five inches, he was an imposing figure as he went on his hospital rounds or stood at a podium to deliver a speech or a lecture. In his Presidential address, he said little about the dangers posed by President Lyndon B. Johnson's "Great Society" and socialized medicine. In contrast to his predecessors, he devoted most of his address to his personal belief that the doctor must be the fiscal agent to conserve the patient's health care dollar. What a novel idea, that we recognize the limitations of the financial resources available for health care and be responsible for how those resources would be used. It is an idea that many of us might have considered more carefully.

In the next issue, we will complete our account of the sixties and "the first hundred years".

* **Bradford J. Murphy, M.D.**, was the Colorado Medical Society Historian for 2 years and was the person responsible for a great deal of the reorganization of the CMS Archives. Principally because of Dr. Murphy's urging, the files were sorted, cleaned, purged and brought up to date through the late 1970s. Dr. Murphy expressed a love of his professional organization and peers, as well as a devotion to preserving the history and culture of the Society. He and his fellow Historians left a great legacy to CMS members which has been honored and greatly magnified through the succeeding years. Dr. Murphy was followed in the post of CMS Historian by Drs. **Hermann Stein**, **Richard Whitehead**, **Cyrus Anderson**, **William Covode**, **Warren Tucker**, **Robert Delaney**, **Wallace Livingston**, and **John L. Lightburn**. During the terms of Drs. Tucker and Delaney, the archives were completely refurbished and refiled.

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by Richard G. Kessel, Ph.D. & Erich G. Kirshner, M.S.

Celebrating the Next 30 Years

The Colorado Foundation for Medical Care (CFMC) is celebrating its 30th year! Anniversaries offer an excellent occasion to reminisce about past accomplishments. However, while we are proud of our past, we would like to use this opportunity to look forward and to thank the many CFMC partners who have made this future possible.

We adamantly maintain that we work with the best physicians and facility personnel in the country and this bravado has proven well grounded. CFMC has earned a national reputation as a leader in clinical quality improvement by collaborating with thousands of physicians and other medical professionals in Colorado. When the Health Care Financing Administration (HCFA) needs an organization to pioneer and lead quality improvement projects with far reaching implications, CFMC is always on the "short list."

This reputation is evident in the number and scope of the many special projects which we lead or coordinate. CFMC is currently involved in projects focusing on heart failure, skilled nursing facilities, end stage renal disease, and Medicare + Choice quality reviews. As the Clinical Area Support PRO for HCFA's national heart failure project, CFMC is charged with providing assistance to the National Heart Failure Clinical Support Team and the entire professional review organization (PRO) community as they work to improve the care of beneficiaries with heart failure. Several practicing Colorado physicians hold influential positions within this program.

Other activities will have a significant impact in future years. Colorado is one of five states participating in the skilled nursing facility project to develop a quality review system to determine the impact of the prospective payment system on the quality of care delivered at these facilities. Similarly, CFMC, with strong community and national input, is developing a method to assess the quality of dialysis care delivered to Medicare beneficiaries with end stage renal disease. The tool being developed will be used by state surveyors in every state. Finally, selection as one of four organizations nationally to provide support for Medicare + Choice HMOs quality assessment and performance improvement programs speaks well for both our clinical expertise and our commitment to quality improvement.

Additional special projects are expected to be announced soon. CFMC has an opportunity to bid on new contracts in areas like pain management, antibiotic resistance, colorectal cancer screening, and the reduction of medical errors.

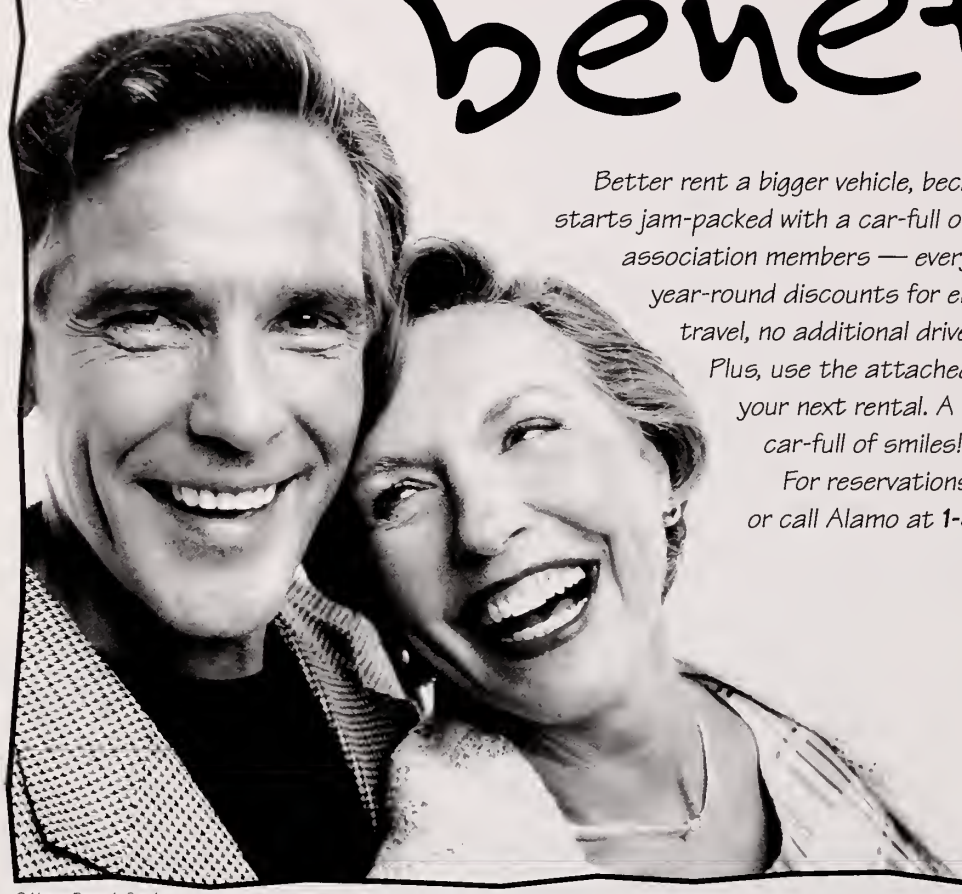
Are we tooting our own horn? Yes and no. The pride we feel in our accomplishments is really a reflection of the esteem we feel for our collaborators. CFMC is chosen for special projects because of the experience, collaborative nature, and quality of the Colorado medical community. By participating in these projects, Colorado physicians are not only having a positive impact on the quality of care within the state, but are also influencing national health care policy.

Colorado Foundation for Medical Care (CFMC) . . . its 30th year.

"Victories along the Western Trail"

As citizens of Colorado we appreciate firsthand the quality of our local medical care. While there continues to be room for improvement, Colorado, on average, continues to outpace the rest of the nation. CFMC's recently released Medicare review annual report is entitled "Victories along the Western Trail" and it highlights both our recent accomplishments and the lessons we have learned. One lesson we will never forgot is to respect the contributions and experience of the physicians of Colorado. If you would like a copy of this report, please contact Erich Kirshner at 303-695-3300, extension 3065.

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by George O. Thomasson, MD
Consultant, Risk Management

Colorado Clinical Guidelines Collaborative

For the past 6 years a large number of health related organizations have been working to create a uniform set of guidelines for key medical procedures by which better care can be assured. This effort has come to be known as the "Colorado Clinical Guidelines Collaborative" (CCGC) and is made up of many organizations acting on behalf of those physicians whom they represent, including:

- Colorado Foundation for Medical Care;
- Copic Insurance;
- Colorado Society of Osteopathic Medicine, and;
- Colorado Medical Society,

whose joining together has created the ***Colorado Clinical Guidelines Collaborative.***

If I were to simply state my feelings about the CCGC, I would find myself echoing the words of the report by Dr. Jean Kutner's project team who submitted this report. I cannot stress enough the need for physician acceptance of the CCGC as a principal guideline resource, not only for furtherance of improved clinical care, but for the protection of the patient AND the physician. I have seen in recent years, the inclusion of "guidelines" in some form or another into malpractice claims and incident and plaintiff briefs. We all realize that there are many sources of clinical guidelines across the United States, and in risk management it is our solid belief that physicians must be in possession of recognized professional guidelines. For that reason, we want you, the physicians of Colorado, to recognize CCGC.

As you will see in the following report, the purpose of this coming together to establish guidelines for medical procedures is not to replace a clinician's judgement. Nor is it to establish a mandatory diagnosis protocol. The purpose is to create a central Colorado resource which can develop guidelines to assist physicians in providing the very best care. I encourage your cooperation and interest.

My specific purpose now is to bring the attention of Colorado physicians to bear on CCGC as a key player in clinical practice guidelines. The goal is to foster recognition of this organization with the realization that it is not just another conglomerate of "good ol' boys" in the medical profession, lending their names to another faceless committee. In those six years that I have been involved, the collaborative effort has taken on a life of its own and is now emerging from the cocoon and has been "morphed" into this "body".

The CCGC has been faced with the problem of developing credibility because it is suspected of being a few physicians who have called on their "friends" to offer opinions in writing these guidelines. To a degree in the earliest stages, this was the case. But the CCGC has now grown far beyond that, which is the purpose of bringing together these organizations to support the concept.

Now, it is time for the "body" to be fleshed out with the opinions and the guidance of experts in various clinical specialties so that broad-based guidelines can be developed.

And that's where you come in:

In the near future, you will be receiving a survey from CCGC asking your recommendations of the respected and influential peers in several different clinical areas. No response from this survey will be shared with any person or entity outside the organizations supporting the CCGC. All persons who have access to the survey responses will be required to sign an Agreement of Confidentiality to maintain this security.

We do need your help! ***Colorado Medicine*** has published three clinical guidelines for use in three specialty areas. The journal publishers agree to do more, as a part of the Colorado Medical Society's support of CCGC. I urge you to begin collecting these guidelines to your own offices, keeping them for any future reference which might be needed. I implore you to respond to the forthcoming survey and help CCGC help YOU!

With those remarks, please read the report on the following pages to further understand what CCGC has been doing in creating this body of experts thus far.

The Colorado Clinical Guidelines Collaborative

Evaluation of Colorectal Cancer Screening Guideline

Project Team Members: Jean Kutner, M.D., M.P.H., Diana Maier, M.P.H., C.P.H.Q., David Werking, D.D.S., M.P.A., and Laurie Shroyer, Ph.D., M.S.H.A.

BACKGROUND

The primary purpose of this project was to identify opportunities for improvement in the guideline implementation phase of the current Colorado Clinical Guidelines Collaborative (CCGC) Colorectal Cancer Screening Guidelines initiative. Although the issues related to opportunities for improvement in guideline development and evaluation may be discussed, these topics were not the primary emphasis of this project.

The specific objectives of this project were to identify the key issues related to physician acceptance and implementation of colorectal cancer screening guidelines promulgated from a central resource (such as CCGC). The use of these CCGC guidelines has always been voluntary – that is, these guidelines were not intended to either replace a clinician's judgement or establish a mandatory diagnostic protocol for all patients eligible for this screening test series.

METHODS

This study represents an inductive, exploratory analysis that identified several possible opportunities for improvement in the CCGC intervention – the CCGC processes related to the distribution of this guideline for colorectal screening.

To this end, three primary care physician focus groups were held to gather qualitative data related to physician's attitudes, beliefs and perceptions about the CCGC colorectal cancer screening guideline. Given the project's budgetary limitations, these groups represented a convenience sample. To maximize within group homogeneity while maximizing between group heterogeneity, the three physician groups represented primary care physicians practicing at different geographic locations (Denver, Longmont, and Boulder). The focus group meetings were held onsite at each practice location. No financial incentive for participation was provided. However, a meal was served to all participants.

Using a standardized approach, the focus group sessions were conducted by a CCGC Evaluation project team of three individuals: 1) moderator; 2) note-taker; and 3) time-keeper/greeter. The focus group sessions were audiotaped for transcription purposes.
The questions were primarily of two types: 1) confirmatory – that is, identifying to what degree the CCGC preconceived notions of physicians may be correct or incorrect; and 2) exploratory – that is, attempting to explore new and different ideas from the group upon which future CCGC actions may be directed.
At the focus group sessions, a written survey from physicians was obtained.

Three of the four project team members participated in each of the three focus group session. Following transcription of the focus group session tapes, the four project team members conducted a content analysis. All four project team members worked collaboratively on the content analysis and review/approval of the final project report. For the content analysis, all the comments to each question were initially organized based on the session's planned sequence. Then these comments were categorized within relevant topic areas and the number of comments counted in each topic area. Based on the summary findings, central themes emerged and possible actions that CCGC might take to improve the current guideline process were identified.

Following the review/approval of this project report, the CCGC Evaluation Sub-Committee will review/approve this document for general distribution. All focus group participants will receive both thank you letter and a copy of the final study report from CCGC.

RESULTS

The number of physicians participating in each focus group varied from 7 to 16 per session. At these three sessions, a total of 32 physicians participated. In general, this project's structured interview

discussion took about 1 hour per focus group.

The average participant age was 46.2 years (median = 44.5, std = 9.8). Since the completion of medical school, the mean number of years that the participant had been in training and practice was 18.6 years (median = 13, std = 11.2). At the focus groups, the medical specialties represented included internal medicine (58%), family practice (19%), and obstetrics and gynecology (6%), as well as from 4 other specialties (17%).

For the most part, the participants had significant exposure to clinical practice guidelines (fair exposure or greater = 64%). However, the participants listed that their actual use of clinical guidelines was overall lower (52% = none or slight use). Predominately, the meetings' focus group participants indicated (based on strongly agree or agree statements) that guidelines are: good educational tools (84%), intended to improve quality of patient care (97%), and likely to improve quality of patient care (66%). In contrast, these participants did NOT perceive (based on neutral, disagree, or strongly disagree statements) that guidelines are: likely to decrease health care costs (84%), intended to improve patient satisfaction (72%), likely to improve patient satisfaction (72%), or likely to improve the physician's job satisfaction (72%).
For the most part, the physician participants (60%) did NOT know the CCGC activities. Prior to the focus group session, the majority of participants (60%) had not received a copy of the CCGC Colorectal Cancer Screening Guidelines.
However, the majority of participants had received colorectal cancer screening guidelines from other sources (65%). The predominant sources listed for these other references included the US Preventive Services Task Force, American College of Physicians, and American Association of Family Physicians, as well as other professional societies and resources. Finally, the majority of physicians were NOT aware of the Medicare reimbursement payment policies for colorectal cancer screening (55%).

In general, the majority of focus group participants did not indicate having seen the CCGC-specific guideline or having access to another colorectal cancer screening guideline. However, the CCGC guideline was noted as being very similar to many of the other guidelines available. Many participants remarked that the CCGC guidelines are consistent with their current clinical practice. From this guideline discussion, it was suggested that perhaps both patient pamphlets and brochures might be developed in the future to assist in patient education efforts. {NOTE: CCGC has previously produced a patient pamphlet.}
Overall, the need for future CCGC-based guideline development and dissemination was questioned.
Where documented by a needs assessment, the CCGC guideline development focus might be best directed to the issues that are possibly uniquely Colorado-based or different for Colorado, such a melanoma. The focus group participants expressed a strong preference for guidelines generally being developed at the national level with local refinement/revision and endorsement (at multiple levels).
Thus, local endorsement and approval will be important to document on future CCGC guidelines disseminated.
Finally, a solution to the problems of differences in the guidelines published from multiple sources needs to be addressed. Any discrepancies between CCGC and other published guidelines should be clearly identified to minimize confusion.
From the perspective of a physician practice, the single greatest need for assistance has been identified as implementation support (such as tracking and follow-up alternatives). Multiple approaches exist to guideline evaluation efforts, but the overwhelming majority of participants are concerned about the large perceived burden placed upon both physicians and patients to comply with guidelines in an environment of diminishing resources. Any support systems to facilitate tracking, follow-up, reminders, and reporting would be appreciated if conducted in the spirit of a continuous quality improvement program – where the goal is to be helpful to physicians within their practice setting, rather than punitive.

In general, wariness related to direct consumer marketing existed. Potential benefits (related to informed consumers) were discussed in context of potential risks. Careful consideration should be given to the risks involved in any direct consumer marketing or outreach effort. CCGC may wish to consider taking a leadership role in making guidelines more user-friendly and practical. Implementation issues and guideline dissemination/training issues will require attention. For COPIC-based (COPIC is **Co**lorado **P**hysicians **I**nsurance **C**ompany) group practices, both COPIC endorsement and training was considered critical. For group practices covered by COPIC, the involvement of COPIC may relate to the long-term success of these CCGC efforts.

CONCLUSIONS

Given that only three focus groups were conducted, the results reported should be viewed as preliminary. More research is needed to fully understand the perceptions, attitudes, and beliefs of Colorado physicians related to CCGC guideline efforts. Given the extensive discussion of the CCGC guideline development and dissemination endeavors, however, there is not a large perceived need for CCGC to continue to provide this ongoing support. Given the CCGC Colorectal Cancer Screening Guideline's similarity to other nationally published guidelines, the value of a separate CCGC effort (without a Colorado-specific unique need) was raised as a question. Future CCGC dissemination efforts should be targeted to minimize guideline

(Continued)

duplication while offering a centralized resource or reference to the large and ever-expanding volume of guideline material available.
Given the reliance of the physician groups upon COPIC for malpractice coverage, the CCGC alliance and collaboration with COPIC should be expanded and strengthened. For example, if COPIC were to endorse the CCGC guideline and stand behind the guideline for risk management purposes, then the possible impact of the CCGC efforts would be greatly enhanced.

From a consumer marketing and outreach perspective, the physicians were extremely wary of any future direct outreach efforts. From this research, it is clear that CCGC is not a recognized name in the guideline business. Thus, credibility of CCGC guidelines needs to be established through endorsement at national, regional/state, and local levels. However, CCGC development of patient materials for use at the local practices (particularly with COPIC and/or national endorsements) would be viewed positively.
For future guideline development, a formal needs assessment should be undertaken. The greater service, however, that is needed in the future relates to both guideline implementation and group practice tracking/follow-up evaluation challenges. A need for support systems has been identified as the CRITICAL COMPONENT related to the success of future guidelines implementation and evaluation efforts at the group practice level.

Finally, issues related to both informed consent, anticipatory guidance, and malpractice risk need to be addressed for the respective roles of the physician practice and physician participant in the future. The role and responsibilities of the patient, as well as patient choices, should be further explored.
In summary, more research is needed to clarify and direct future CCGC policies and procedures. However, a solid foundation for these future research efforts has been laid by this initial exploratory physician focus group project.

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COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



A Rich Legacy and a Bright Future

This year, Copic Insurance Company is producing a videotape documenting our early history. As part of that project, Robert S. Brittain, M.D., Copic's first Physician Risk Manager, was interviewed. His interview made me think about how much we've learned over the last 28 years and how fortunate we are to be able to offer our insureds such depth of talent in this field now and into the future.

In 1972, Bob Brittain and the CMS Risk Management Committee began reviewing closed claims from the CMS-sponsored Hartford malpractice program. Carefully, they teased out the critical elements and associated losses. When they were done, they had created one of the first-ever comprehensive collections of risk management knowledge. Bob was intrigued by the idea of helping physicians learn from their mistakes and those of others. With Medical Liability Consultants Program (MLCP), the corporation he eventually formed, he gained a national reputation as a leader in this exciting new area.

When Bob needed to devote more time to consulting, he found his successor in George O. Thomasson, M.D. George was a true believer, and he deserves much of the credit for moving not only Copic but other physician-directed malpractice companies across the country as well toward an approach that centered on commitment to six core principles:

1. Defining the medical risk issue
2. Developing an education program for the entire team, not just the physician(s)
3. Providing a "tool kit" to assist in implementation at the practice level
4. Monitoring effective implementation in each insured practice
5. Providing focused assistance for practices experiencing implementation problems
6. Protecting physicians by eliminating from the risk pool those practices which, after a reasonable time, fail to demonstrate useful implementation.

In recognition of his role in the advancement of risk management knowledge and practice, George was asked to chair the Risk Management Section of the Physician Insurers Association of America (PIAA) -- a position he held for many years. George states that he feels fortunate through his learning experiences with Bob Brittain and Copic to have been able to help redirect the Risk Management Section from the "classic claims-based orientation to an anticipatory evidence-based concept stressing the importance of behavioral change and effective communication skills for physicians and members of the health care team."

Today, Copic's Risk Management department is under the leadership of Richert E. Quinn, Jr., M.D., a gifted surgeon with a keen interest in applying databases, statistical evaluation, and data modeling to risk management. Assistant Vice President Kathy Gardner, B.S.N., Ph.D., shares her expertise in physician-patient communication to teach practices critical skills that can make all the difference in preventing and addressing problems with patients. Evonne Domoney, B.S.N., M.A., helps office staffs implement systems to manage these risks, thereby "closing the circle."

Physician Risk Managers Marjie Harbrecht, M.D., Alan Lembitz, M.D., and Jeff Varnell, M.D., round out Copic's range of expertise. Marjie's research into our breast cancer delay of diagnosis claims led to the development of new Copic guidelines for breast lumps and lesions, as well as to the creation of a complete multidisciplinary disease-state management system now being tested among Copic-insured practices. Alan has ably assumed the mantle of Copiscope editor from Rich, and brings a dedication to providing evidence-based, timely risk management guidance and practical direction for its application. Jeff's examination of our general surgery claims led to the formulation of new guidelines and consent forms for laparoscopic procedures as well as prevention of deep vein thrombosis.

These dedicated professionals are deeply committed to serving Copic's insured physicians, and they are eager to share their expertise with you. I encourage you to draw on their knowledge and assistance. You can reach Copic's Risk Management department at (720) 858-6000 or (800) 421-1834.

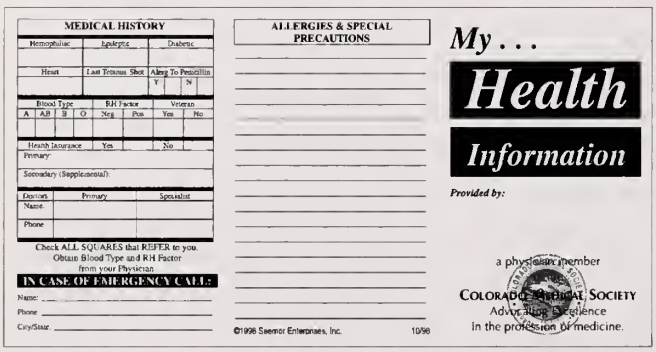
Are your patients fully aware of their medications?

How do your patients remember what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions. That's a lot to remember, but here's a way to help them.

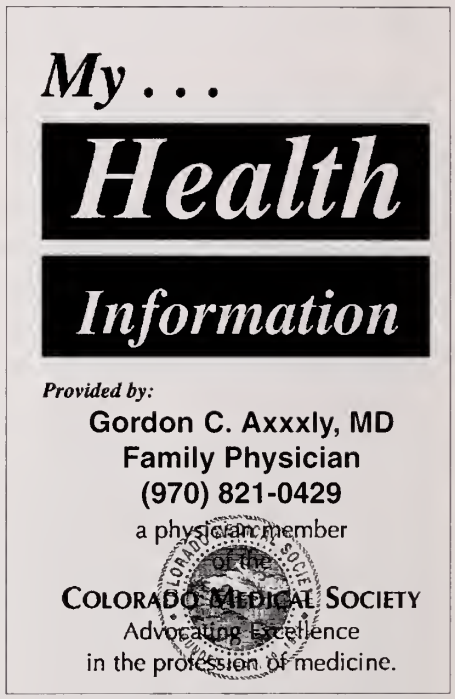
Every day you remind your patients to follow your directions exactly. Even so, we hear of patients taking seriously conflicting substances, such as using an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among older citizens.

Here is a device you can give your patients which will help them remember their current medications , the dosage and the schedule. It is a handy, pocket-sized card which is constructed of sturdy plastic. . . and the card can be written on if the prescriptions change.

The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as the medical needs change. The card will hold up a long time.



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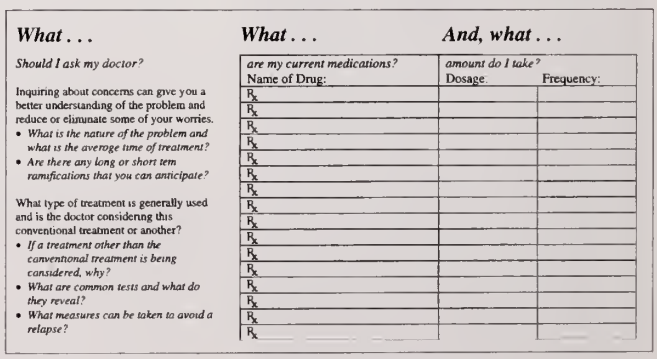
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The overall response from the July mailings to the Denver Metro and Colorado Springs CPN Primary and Specialty physicians has been most gratifying. As outlined in last month's article, our physicians in this region were offered the opportunity to accept an enhanced reimbursement level as of September 1, 2000, linked with the commitment to intensify a sense of partnership with CPN – RMHMO, and proceed with any payment of any residual of the CPN initial membership fee.

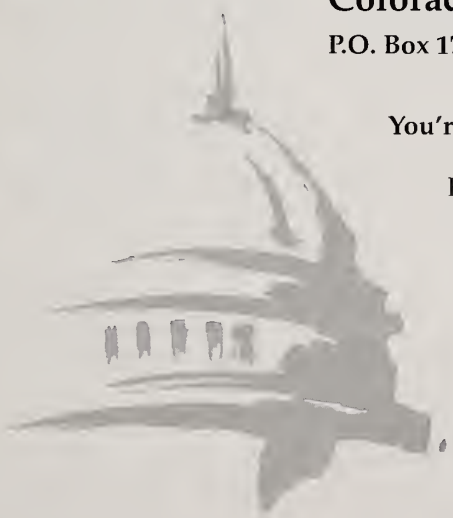
63% of our 265 regional PCP's contacted have responded affirmatively. Only 8% declined by formal reply. The remaining 29% have been re-notified that non response is equivalent to declining, since active endorsement is an essential component for future growth. Of the 1101 specialists offered similar options, less than 2% have declined to accept the combination of enhanced fees and commitment.

We are most gratified for this demonstration of continued support for our efforts to keep physicians centrally involved in Colorado managed care. Individual and group meetings with our physicians are being planned in the near future to communicate personally about mutual concerns, opportunities, and potential solutions.

Thank you for your ongoing continued participation in these complex times!

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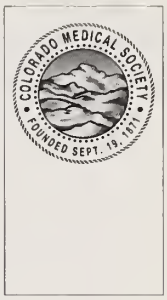
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

Pioneer Spirit!

This has been a particularly interesting summer, due to a special project. The project is one of reviewing the history of the Copic Insurance Company and setting it down in perpetuity. The purpose of this exercise is to be sure to have a recorded history of the company, its founders, its founding, and the reasons for its founding. It is a fascinating history.

The part of the story that is most engaging is seeing the seed of an idea planted, watching as the seed is nurtured, cultivated (prodded), etc., and growing into one of the healthiest plants of its species in the whole world!

I was a minor participant in the early days of this phenomenon . Now, looking back and recapping each participant's part, here's what I have found:

I have determined that the unqualified success of Copic as a major insurance player is due, not just to the assembly of a body of knowledge, but to the spirit of the people involved. Each of those *"Copic pioneers"* will say that it was the challenge; it was necessary in order to continue a satisfying medical practice in Colorado. Each will tell you that it was the *"Copic spirit"* that permeated everything everyone did or said. To a person, all of these pioneers say that "Doctors just weren't good at business". Yet this not-for-profit trust which started without a nickel to its name has metamorphosed into a blue-ribbon performer for almost 20 years in a field crowded with for-profit corporations touting millions and billions of dollars in cash reserves. Well, it wasn't only business sense that did it; it was the heart and soul. . . the spirit of the people involved.

When the five members of the (then) CMS Board of Trustees became the first members of the Board of Directors of the *CMS Professional Liability Trust*, none of them knew where he or she was going to end up. But they took on the task of convincing thousands of other physicians to join them. They succeeded, almost a dollar at a time, in raising enough capital to start a professional liability insurance program for Colorado doctors.

We've watched the idea grow from that humble beginning to the day when it became necessary to distance itself from its founder, CMS. In its next stage, it changed into the *Copic Professional Liability Trust*. Not long after, it grew into the *Copic Insurance Company*. Now, it has grown in multiplicity to *The Copic Companies*, embodying numerous business resources, all still serving the physician and his/her practice.

All this is not written as a "pat on the back" of a bunch of do-gooders. It is a written recount of a real phenomenon involving a large group of people. No one person can be singled out as "the" reason Copic has succeeded; success has been the result of the leadership of many, the sustained spirit of hundreds of Colorado doctors. It was a product of the realization by thousands more that Copic is a Colorado phenomenon nowhere duplicated or repeated in the world of insurance.

It's been fun to go back and reviewing the minutes of many meetings, remembering that some Board members sat aghast at what was going on, remembering expressions of disbelief (yes, there were some naysayers) and wonderment of how CMS could ever pay even one malpractice settlement of $25 thousand or more. It's also been interesting to review that there wasn't much choice: the doctors had to take control of their own lives. The whip saw effect of major for-profit insurance companies versus traditional medical practice was not a part of professional satisfaction.

And so, an idea whose time had come was born in the mid-1970s. It came into the world a foal, barely able to stand on its own legs. It lived and grew into a workhorse that has toiled for the success of much of Colorado's medical practice, replacing the stalking horse of the outside, for-profit companies. Its energies have been successfully harnessed for the good of doctor and patient.

Of course there were a number who practiced the age old act of floccinaucinihilipilification*: the habit of estimating the idea as worthless. Fortunately, there were countless others who determined to stay the course; boustrophedontic*, as it were (as the oxen goes, so goes the plow.)

*It's tough to work some words into a conversation or a story.

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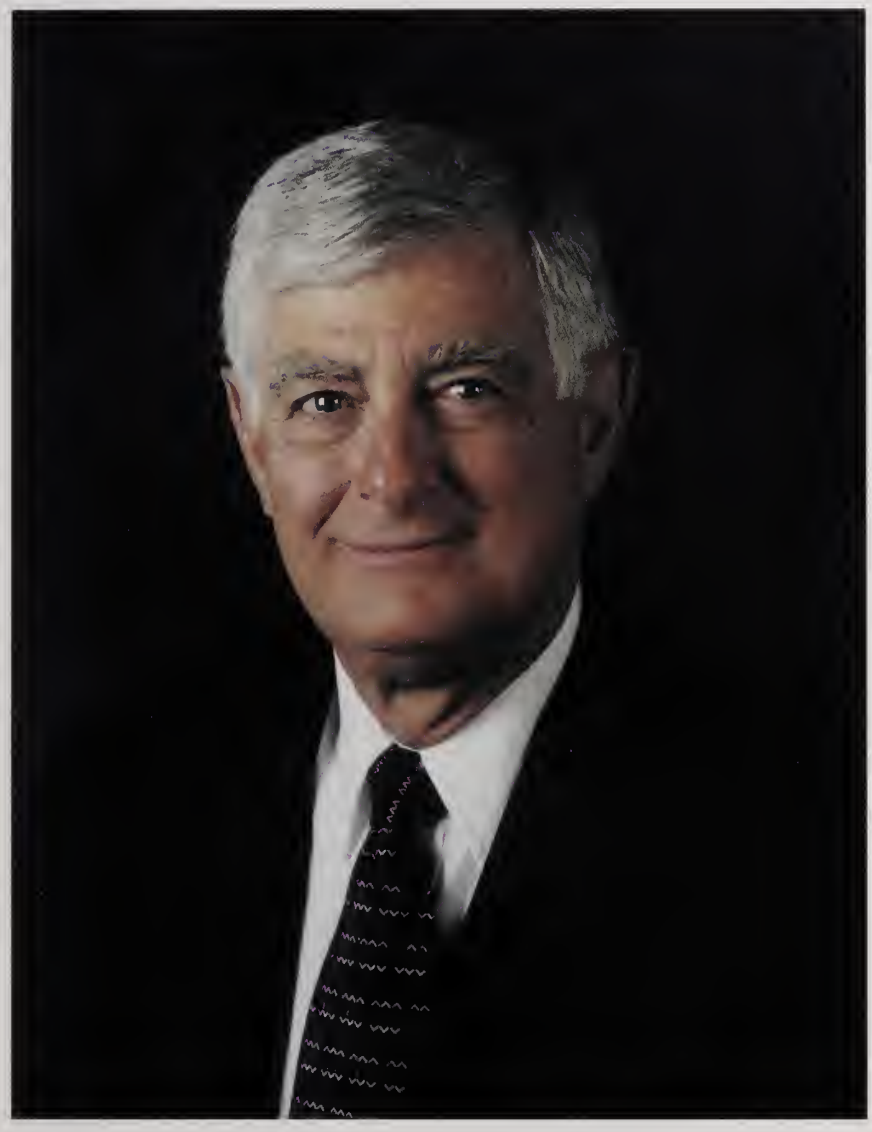
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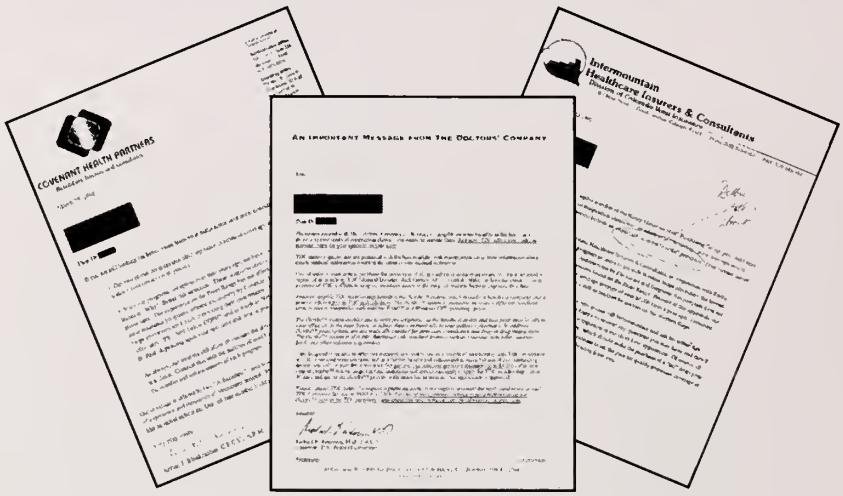


Richard Allen, MD, President
Colorado Medical Society, 2000-2001

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COLORADO MEDICINE

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO 80230-6902. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Denver, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Richard Allen, MD
President 2000-2001
Colorado Medical Society

September 23, 2000 Presidential Inaugural Address

I have chosen to address you using the CMS slogan and the theme of today's educational program, ***"Advocating Excellence in the Profession of Medicine."*** This is a continuation of the theme that we put forth in the Vail conference last May on rediscovering and redefining medical professionalism in regards to ethics, the science of medicine, and education. Since our meeting in May, I have had innumerable articles and items of interest come across my desk. For example, here is an invitation to attend the University of Michigan Medical School symposium entitled, "Will Professionalism be a Casualty of Modern Medicine?" "Casualty" is in bold letters. I also have the July 24th issue of American Medical News with a front page article entitled, "Physicians Enticed into Early Retirement." It is subtitled, "Frustrated by Managed Care Regulations, Doctors are Leaving the Bedside Earlier than Ever." Another article entitled, "Malaise is Spreading Through American Medicine" can be found on page 12 of the AM News, and it starts out by saying, "If American medicine were a patient, it likely would be diagnosed as clinically depressed. A recent set of focus groups involving physicians on problems and problem solving unveiled an alarming expression of rage, skepticism and hopelessness. These doctors felt embattled. They were loathed to trust any solution for the problems they faced. The sources of frustration were many. They were financial, legal, professional, and personal issues that denied them the sense of achievement they expected from their practice. The participants in the focus group perceived a growing disdain in this country for medical practice and for physicians. It was as if society somehow forgot the value that medicine offered. These doctors were not merely whining: they were quite concrete in what was bothering them."

There can be no doubt that medicine today is under siege from various market forces, and that it's professional values, indeed its very identity as a profession, is under threat. Our distress reflects a fundamental clash of values. I feel we need to focus on what is good about the practice of medicine. Only by adhering to professional values, and maintaining the high standards of medical professionalism, will we be able to weather the storm that continues to buffet us. As we enter this new millennium, I feel it is appropriate to define and underscore the service role of physicians and the educational support that is required to carry that role into the 21st century. We've built the bridge to the 21st century and we're not going back.

Many of you know that one of my other roles this year is chairing the Council of Medical Education of the AMA. At the Vail conference in May, we had a number of speakers present the challenges facing the medical education community in terms of funding of both undergraduate and graduate medical education and the pursuit of continuing medical education as a life long learning. One of the projects that the Council is working on is a collaborative effort with the Canadian Medical Association (CMA) in addressing these needs in the next century. Both the AMA and the CMA are professional organizations of physicians that have the goal of improving the practice of medicine and the health care of the public. Both organizations have a long history of involvement in setting the standards for medical education, and have the skills and experience that is needed in continuing medical education and continuing physician professional development. While the profession as a whole has been subjected to withering criticism from a variety of sources, it is clear that individual physicians are still held in very high regard by their patients. In significant measure, this is due to the devotion of service that generations of physicians have shown, in particularly over the last century. The challenge before us is to ensure that this devotion is carried undiminished into the next century. The primary mechanism of so doing is the life long education, not only of new but also existing physicians. The profession as a whole does have some

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Presidential Inaugural Address

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ground to regain in justifying its ongoing existence as a self regulating profession in a democratic society. This is exemplified by the education program that we had this morning. The changes that challenge us can only be met if we have a coherent and shared vision of what it means to be a professional, what it means to be a doctor and what it takes to make a doctor.

The practice of medicine evolves rapidly, stimulated by new knowledge, new technology, and changes in the system for the organization and delivery of health care. Physicians must keep pace, not only in their clinical discipline, but also in other areas such as communication skills and resource management. To do this, physicians must engage in the process of life long learning, beginning in medical school and continuing throughout the rest of their training and professional life.

It is important to emphasize that there are several fundamental characteristics of any profession. Among those characteristics are that training is intellectual and deals with the acquisition of specialized knowledge, that work is pursued primarily for others, and that success is measured by more than financial return. There is a moral and ethical dimension as well, and professional work has public value that must serve the public's welfare. Contrast these fundamental concepts of a profession with the concepts of the marketplace. The country has long enjoyed and benefited from a market economy. There is nothing inherently "evil" or "wrong" in market values. Indeed, through much of the 19th century, a new company's articles of incorporation had to identify the public good that would be served by the new business. Unfortunately that is no longer true.

Market values often prevail at the expense of all others. Hence, we speak of the health care industry. Physicians are "employers" or "providers," and patients become "consumers." Indeed, in a report from the Hastings Center a market ideology has only the moral obligation to seek profits competitively. There are significant differences between market values and traditional professional values. While these differences apply to all professions, in none are they more disparate than in medicine. Businesses value profit, while professions value service. Businesses work on a competitive model, the professions on an advocacy model. Businesses are driven by stock holders, not by altruism. Professions set and maintain standards internally, contrasted to the external market forces that set business standards. Businesses are typically driven by short term goals that are designed to give society what it thinks it wants at the moment, while professions are typically driven by long term goals that hope to meet societal needs.

These differences represent a true clash of values. Herein lies much of the conflict between the business of medicine and the practice of medicine. The market model is reshaping professional practice in ways that threaten to obliterate any distinction between the professions and business. The result seems to be an unmistakable erosion of professional identity and morale. Is it any wonder then, that we physicians have felt such acute discomfort as the US health care system has been driven into a corporate model? The debate about health care has been dominated not by physicians, but by business, economic and political interest. We are not happy with the current situation, yet we remain perplexed about how to approach the problem and what to do about it. We are perplexed, I would argue, because medicine has become distracted from its traditional, time honored goals and hence is in danger of losing its distinctive voice.

Well, what can we physicians do, both individually and collectively, to restore that distinctive voice, to ease the discomfort of practicing in a new corporate age, and to reassert the primacy of professional values in our care of patients? The answer, I believe, lies in professionalism. At last years meeting, I showed you a short video tape of Dr. Andy Anderson's message to the AMA. Simply put, it was that physicians have only one obligation and that is to ask the question, "Is it good medicine?" Thus, while it may be difficult to maintain professionalism in today's environment, I believe it can be done. The challenge is how to do it. I believe we must find ways to reaffirm and strengthen those values that have for so long epitomized the practice of medicine. We have a duty to do so both as individual physicians and as a profession.

So what can be done? There are several ways in which individual physicians can reaffirm their own professional values. First is in our role as educators. One of the classic duties of a profession is to train subsequent generations. As the medical school curriculum changes to reflect advances in biomedical science, so too must there be change to address explicitly the issues of medical practice. Until recently, our undergraduate medical education had paid little attention to the nature of professions and the specific professional responsibilities of physicians. It was assumed that students would somehow automatically become cloaked with the mantle of physicianhood. But as the practice of medicine has changed, medical schools have begun to recognize that they must deal more directly with such issues. This is also true of graduate medical education where the various residency review committees have now been required to put into their professional program requirements courses in ethics and communication skills. As a member of the Executive Committee of the Accreditation Council for Graduate Medical Education, last year we adopted six core competencies for residents. These dealt with six broad categories of patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and system based

practice. The ACGME has said of professionalism that "all residents upon the completion of their training must demonstrate respect, compassion and integrity; they must respond to patient and societal needs, remain accountable to their patients and their profession, and be committed to excellence. They must demonstrate a commitment to ethical principles and remain sensitive to cultural and other factors." The tasks now assigned to the RRCs are to address the elements of professionalism: namely that their residents demonstrate a high degree of personal responsibility, that they apply ethical concepts that take into account not only individual patients but also broader communities, and that they be able to foster a trusting relationship with patients. Such objectives provide a part of a foundation on which residency programs can build. While formal educational efforts are under way at both the undergraduate and graduate levels, even more important are the informal ways in which professionalism is conveyed in almost everything we do. Practicing physicians and medical school faculty are powerful role models. Think back to your own training. I dare say that everyone here can name one or two individuals who were pivotal mentors. In today's corporate age, mentorship becomes ever more crucial, but it is often placed in jeopardy by the demands of practice. I cannot over emphasize the impact, both positive or negative, that we have on physicians in training. We must strive to recreate opportunities in which we can more effectively serve as positive role models for medical students and residents.

Last year, at the AMA's House of Delegates, Dr. Ron Davis gave a speech in which he paraphrased Lincoln's Gettysburg Address. I would like to read for you just the last part of that address: "The world will little note or not long remember what we say here. But it can never forget what we do here, if we dedicate ourselves to the great tasks remaining before us:

- to put the interests of the patients above all else
- to protect the sanctity of the doctor-patient relationship
- to uphold the ethical and clinical standards of medicine, and
- to build a new alliance of physicians, who will speak with a unified voice, to oppose those who would sacrifice patients at the alter of the almighty dollar.

If we here highly resolve to increase our devotion to accomplishing these tasks, then this association shall have a new birth of freedom. And this association - of physicians, by physicians, and for our patients - shall not perish from the earth."

In the hustle and bustle of a busy clinical setting, especially when there are severe external pressures driving a business model, it is easy to lose sight of how important the patient-physician encounter is to our patients. What may seem routine to us is almost invariably not routine to our patients. We must remain cognizant of how important our professionalism is to our ability to foster a healing relationship. We must consciously recall our fiduciary responsibilities to our patients, so that their interest remain paramount. We must evince humanistic values such as compassion and empathy. It is gratifying that some of the terribly restrictive practices imposed by managed care, such as the length of time a woman can stay in the hospital following child birth, are beginning to ease. But much remains to be done. As advocates for our patients we must help make the arguments that will result in other needed changes. As individuals then, we physicians can do a lot to foster professionalism, though it will require determination and a commitment by each of us.

Let me close by considering briefly our collective responsibility as a profession. "The profession, through its practice leadership, as well as its organized bodies, must sustain the covenant of trust that has long characterized the relationship between medicine and those it serves.[1]" Professionalism has long been symbolic of a mutual trust between patient and physician, as well as between the profession and the larger society. To regain the public's trust, and hence the public support, we must be able to inspire reforms and be willing to assume new responsibilities as part of our social contract. We must now accept accountability not only for the traditional roles of our profession, but also for the economic and political milieu's in which the practice of medicine occurs. We face difficult but critically important challenges, challenges to which professional societies must rise.

In order for medicine to regain its professional status, it must speak with a stronger voice - a voice that speaks not of physician's interests but of patient's interests. We must continue to ask the question: Is it good medicine? Professional organizations must actively advance medical professionalism as the means by which the profession willingly accepts responsibility for both the long established and the emerging obligations we have to our students, our patients and our society.

Too often, organized medicine has failed to articulate effectively the importance of professional values to our work and to our patients. We have failed to articulate effectively the primacy of these fundamental values and attributes that impel the healing encounter between patient and physician. We have failed to articulate to government agencies and to payers and to others the long term risks that arise when medical practice is driven exclusively by "the bottom line," when medicine becomes a commodity. We must proactively work to reaffirm the pivotal nexus of the patient-physician covenant. We must embrace a sense of social trusteeship that reflects our duty to provide a public good. We must argue persuasively that only by maintaining medical professionalism will physicians be

1. *Swick, HM. "Toward A Normative Definition of Medical Professionalism," Academy of Medicine 2000, 75 (6), June Issue.*

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Presidential Inaugural Address

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truly able to meet their responsibilities to individual patients as well as communities. Together, we must make the case. I hope that the Colorado Medical Society's voice in the ongoing dialog will be a loud one. Let me give you just two examples of what CMS is currently supporting. We are supporting the Colorado Foundation for Medical Care's patient safety initiative, which was addressed in this morning's educational program. We must be able to assure the public that they have a competent physician. Secondly, we are participating with the Coalition for the Medically Underserved in their goal of providing all Coloradans with "unimpeded access to affordable, quality health care." (That is in their mission statement). This is what physicians do. They advocate for competency, patient safety and patient access to health care. The past few years have been very challenging, and the next few years will remain so. But we can look to the future with hope if we, individually and collectively, insist on holding fast to those values that have for so long guided the practice of medicine. That is, the promise of professionalism. It can help us weather the storm. If we insist on adhering to high standards of medical professionalism in our teaching, in our practices, and through our societies, we will go a long way towards meeting our responsibilities as a profession, and perhaps most important of all, we will restore our own sense of pride and joy and our fulfillment in our calling.

Thank you.

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Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Mental Illness and the Duty to Warn/Treat

By Patrick T. O'Rourke, Esq.
Montgomery Little & McGrew, P.C.

Imagine this situation:

You are a physician in a rural emergency room. A person comes into the emergency room and asks to see a physician. When you enter the room, the patient describes for you that she has recently been fired from her employment and has been having fantasies about killing her former boss. She states that she has recently purchased a handgun and could "snap" the next time that something stressful happens to her. The patient's demeanor is calm, but serious, and you have no indication that the patient is joking. In addition, the patient indicates that she has been depressed for several weeks and believes that she has "no reason to keep going." Immediately after telling you this story, the patient says that she "feels better now that she has this off her chest" and begins heading for the door. What can you do?

Colorado law give physicians two tools that they can use when confronted with patients who may represent a threat to themselves or others. These tools are: (1) the ability to institute an emergency psychiatric hold; and (2) the ability to warn potential victims.

A. Emergency Psychiatric Holds

Colorado law allows "intervening professionals," including all licensed physicians, to undertake an "emergency procedure" when a person: (1) appears to be mentally ill; and (2) as a result of mental illness, the person appears to be an imminent danger to himself, an imminent danger to others, or is gravely disabled. *C.R.S. §27-10-105(1).*

As described immediately above, a physician may not institute these emergency procedures unless the person is "mentally ill." Colorado law defines a "mentally ill person" as someone with "a substantial disorder of the cognitive, volitional, or emotional process that grossly impairs judgment or capacity to recognize or control behavior." *C.R.S. §27-10-102(7).* Mental retardation is insufficient to justify a finding of mental illness. *C.R.S. §27-10-102(7).* The Colorado Supreme Court has also noted that a person's idiosyncracies or eccentricities may not justify a finding of mental illness. *People v. Taylor*, 618 P.2d 1127 (Colo. 1980).

If a person appears to be "mentally ill," the next inquiry is whether that illness is causing the person to be an imminent danger to himself or others. If so, the mental health professional may institute emergency procedures. If not, the mental health professional should assess whether the mental illness has caused the person to become gravely disabled. A person is "gravely disabled" when his mental illness has placed him in risk of serious physical harm due to his inability to provide himself with the essential human needs of food, shelter, clothing, and medical care. *C.R.S. §27-10-102(5)(a)(I).* A person may also become "gravely disabled" when his mental illness causes him to lack judgment in the management of his resources or in the conduct of his social relations to the extent that it has endangered his health or safety. *C.R.S. §27-10-102(5)(a)(II).*

If the prerequisites for the emergency procedures are

(continued on next page)

met, the health care professional may take the person into custody at an institution that provides treatment for mental illness for up to seventy-two hours of treatment and evaluation. *C.R.S. §27-10-105(1)(a).* Upon admitting a person for a seventy-two hour evaluation, the intervening professional must complete an application stating the circumstances under which he became aware of the patient's condition and stating facts establishing the patient's mental illness and the reason why he believed the patient was an imminent danger to himself or others or was gravely disabled. *C.R.S. §27-10-105(2).* The application must also state the time when the patient was taken into custody and the name of the person who first brought the patient to the intervening professional's attention. *C.R.S. §27-10-105(2).*

A recurring question is whether the intervening professional must have personally observed facts demonstrating that the patient is a danger to himself or others, or whether the intervening professional may rely upon the observations of others in formulating the probable cause necessary to order a seventy-two hour evaluation. The relevant statute states that the intervening professional must state sufficient facts either obtained from "personal observations" or "obtained from others whom he or she reasonably believes to be reliable." *C.R.S. §27-10-105(2).* Accordingly, it appears that the intervening professional may rely upon reliable advice obtained from others when determining whether to order a seventy-two-hour evaluation.

Although the statute allows up to seventy-two hours for a physician or licensed psychologist to complete an evaluation, it also specifies that the evaluation must take place as soon after admission as possible. *C.R.S. §27-10-105 (4).* Upon the expiration of the seventy-two hours, the physician or licensed psychologist must release the patient, refer him for further care and treatment on a voluntary basis, or certify the patient for involuntary treatment. *C.R.S. §27-10-105(4).* If, in the opinion of the physician or licensed psychologist conducting the evaluation, the patient can be properly cared for without being detained, all further services must be on a voluntary basis. *C.R.S. §27-10-105(3).*

B. Duty to Warn

Physicians are often confronted with a conflict between the patient's right of confidentiality and the professional's duty to protect others from harm when a patient has made a serious threat against another person. In that situation, the physician's failure to disclose the threat could lead to another person's death or bodily injury. Indeed, several courts recognize that a mental health professional may have a duty to warn potential victims of serious threats. *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976); *Perreira v. State of Colorado*, 768 P.2d 1198 (Colo. 1989).

Colorado has tried to clarify this area by enacting a specific statute delineating the mental health professional's duty to warn. *C.R.S. §13-21-117* provides that no mental health professional, including physicians, or institution shall be liable for damages in any civil action for failure to warn or protect any person against a mental health patient's violent behavior, unless the patient has communicated "a serious threat of imminent physical violence against a specific person" to a physician and the physician failed to provide any warning.

Accordingly, when a mentally ill patient has communicated "a serious threat of imminent physical violence against a specific person," the physician's duty is to make "reasonable and timely efforts to notify any person or persons specifically threatened." Additionally, the physician must notify an "appropriate law enforcement agency" of the threat. By making these warnings, the physician satisfies any obligation he owes to a third person, even though it required him to disclose otherwise confidential information.

In those circumstances where the physician believes that the patient's action has triggered the duty to warn, he should also strongly consider whether other "appropriate action," such as hospitalizing the patient for an emergency evaluation, is also prudent. Although patients have a legitimate right to object when a physician curtails their liberty without good cause, Colorado law recognizes that some deprivations of liberty are appropriate, and even necessary, to protect the general populace.

C. Conclusion

Decisions about whether to institute an emergency psychiatric hold or whether a physician should warn a potential victim about a patient's threats raise difficult medical and legal questions. One of the primary difficulties is that the physician encountering a mentally ill patient for the first time may not have the luxury of reflecting on the decision or an opportunity to consult with other physicians. Colorado law attempts to protect the physician's ability to "do the right thing" by giving the physician discretion to institute treatment and to warn potential victims. In uncertain cases, however, physicians should consider consulting with a qualified attorney to determine if the statutory prerequisites have been met.

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CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

Clinical Diabetes & Endocrinology in 2001
January 20-25, 2001
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Amy Dohr: (800) 421-3756 or (303)798-9682

20th Annual Big Sky Pulmonary & Critical Care Medicine Conference
March 21-24, 2001
Big Sky Ski Resort
Big Sky, Monatana
Contact: (406) 442-6556

Effective 10/1/00 some Medicare functions will be transitioned to a new carrier.

Beginning October 1, 2000 the post-pay medical review and fraud and abuse functions previously performed by the Medicare Part B Carrier for Colorado (Noridian) will be transitioned to Computer Sciences Corporation (CSC) and its subcontractors. Noridian will continue to handle the development of local medical review policy and pre-payment medical review, as well as the claims processing and customer service activities. Dr. Grant Steffen will remain the Carrier Medical Director for Colorado. This transfer of functions is in line with the Medicare Integrity Program (MIP) which was enacted by Congress in 1996 as part of the Health Insurance Portability and Accountability Act. Under the MIP the Health Care Financing Administration (HCFA) has the authority to establish separate contract arrangements for these program integrity functions in order to safeguard the Medicare dollars. As more details become available on how CSC plans to transition the work we will let you know.

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

MSNJ prompt pay survey shows physicians' discontent, names names.

Eighty-three percent of New Jersey physicians said they have experienced excessive delays by HMOs in processing claims, according to a survey published in the September issue of New Jersey Medicine -- the health policy journal of the Medical Society of New Jersey (MSNJ). The study was conducted immediately prior to a New Jersey prompt pay law taking effect.

"Before this survey, any information provided by doctors on the efficiency of HMO reimbursement was considered hearsay or subjective," said Walter Kahn, MD, MSNJ president. "This survey validates the concerns and dilemmas facing physicians and proves that some HMOs have been more efficient in payment methods than others."

According to the survey, "35 percent of responding physician practices experienced payment delays across all HMOs of greater than 30 days when filing electronically, while only 50 percent of those who filed manually were paid within the time frame stipulated by the new prompt payment law." The law stipulates HMOs must pay electronic claims within 30 days and manual claims within 40 days.

MSNJ believes that survey results will act as a baseline to gauge future payment performance. The study cites Aetna, AmeriHealth, Cigna, PHS and Prucare for routinely exceeding 40 days for payment of manual submissions. Cigna and AmeriHealth were named for leaving the average manual Medicare submission payments more than 50 days overdue.

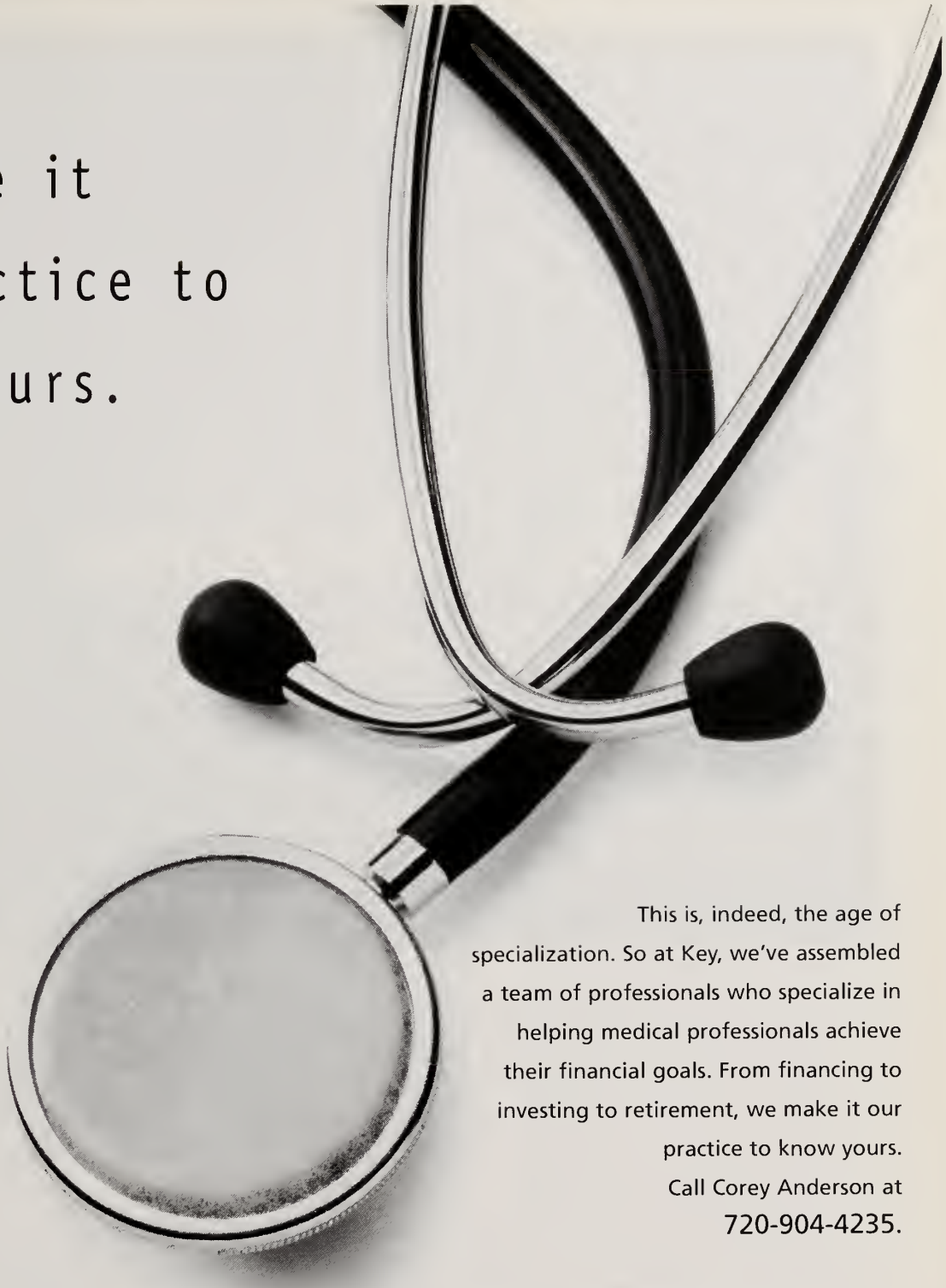
PHS, Horizon, AmeriHealth, and Prucare were cited by the MSNJ survey as significantly negligent for paying interest on delayed claims. Despite repeated requests from New Jersey Medicine, only Aetna issued a brief statement regarding its results.

AMA President Randolph D. Smoak, Jr., MD, applauded MSNJ's success in "collecting data that proves health insurers are consistently delaying payments to physicians."

The survey also was accompanied by an editorial from N.J. Governor Christine Whitman, who said that "delays in payments, unreasonable bureaucratic hurdles, and other process issues are unfair to everyone and can even impede the delivery of essential healthcare."

Read the study on the MSNJ Web site. For additional information, e-mail MSNJ's Neil Weisfeld or phone (609) 896-1766. For more information on the AMA's prompt pay initiatives, e-mail Matthew Katz or phone (312) 464-5921.

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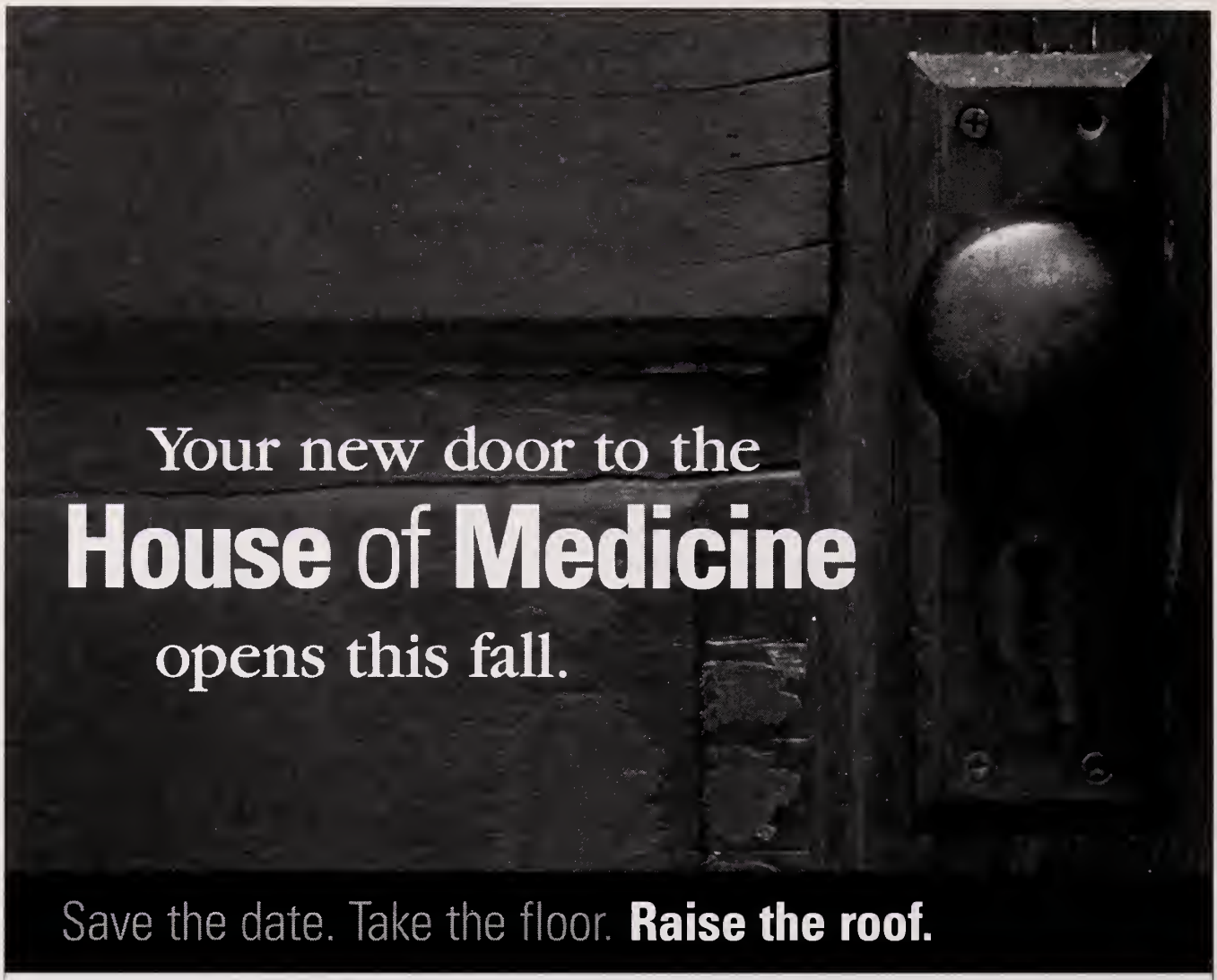


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PrivateBank Healthcare



For the first time ever, the American Medical Association Organized Medical Staff Section will open its door at the Interim Meeting to all physicians — regardless of practice affiliation or membership status — at a unique "Open House" gathering in Orlando, Florida, November 30 through December 4, 2000.

Your advocate for positive change.
The AMA wants to help you overcome the incredible challenges you face. Reduce onerous regulations and managed care demands. Protect your autonomy and patient relationships. Ensure appropriate reimbursement. Make sure no one treats physicians like commodities.

Your place to speak up.
To help unify the AMA and the nation's front-line physicians, this one-of-a-kind meeting offers you a direct avenue for raising your issues and concerns and proposing solutions.

Your opportunity to act.
The AMA will open the door. It's up to you to step through. And because your participation is so important, there's no fee. Just sign up and attend. For more information, call **800 262-3211,** or visit us online at **www.ama-assn.org/omss**

Register today!

AMA Organized Medical Staff Section (OMSS)
2000 "Open House" Meeting
November 30–December 4, 2000
The Hilton in the Walt Disney World Resort
Orlando, Florida

American Medical Association
Physicians dedicated to the health of America

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Do You Know EMTALA?

Enclosed is a handy reference booklet to help you get to know EMTALA (Emergency Medical Treatment and Active Labor Act).

In 1998, the Colorado Health and Hospital Association (CHHA) held the first of two two-day seminars to educate hospital administrators, legal and medical staff members and physicians about EMTALA.

Even though this federal anti-dumping law has been on the books since 1986, enforcement has just recently become an issue. Therefore, the CHHA seminars held in Denver were of considerable value. Not many physicians were able to attend because of their practice requirements.

EMTALA, admittedly, affects emergency on-call physicians, but through the seminars and presentation of real-life scenarios, it was obvious that an unknowing physician outside the hospital emergency department might easily get into an "EMTALA situation". The outcome? **Serious physician liability.**

Realizing that this anti-dumping law not only involves the hospitals and ancillary health care personnel, the American Medical Association has recently made available the "EMTALA Quick Reference Guide for On-Call Physicians". Published by the AMA Organized Medical Staff Section, the "Quick Reference" is not meant to be a *"show-all, tell-all"* about EMTALA, but it will certainly help on-call physicians in a majority of situations avoid the pitfalls of non-compliance.

Remember, this emergency treatment law applies to all hospital treatment. It applies to any patient who seeks care, whether through the hospital emergency department or any other department!

Here's an example: you are the on-call physician and you are summoned by telephone to the hospital to attend to a patient. You say you will be at the hospital as soon as physically possible. How soon? You say you'll be there in "30 minutes." You don't arrive within 30 minutes and a case is made to Health Care Financing Administration (HCFA) that you, the physician, did not respond in a timely manner. Result? Medicare-participating hospitals and the physician involved might both be sanctioned. Civil monetary penalties for physicians can be up to $50,000 per violation. **DO I HAVE YOUR ATTENTION?**

Colorado Medical Society staff and leadership have, for some time, been wrestling with the idea of providing its membership with a general EMTALA briefing; however, neither the occasion nor the opportunity has occurred. The AMA has filled the breach with this Quick Reference Guide. We encourage you, physician or medical staff person, to remove this information from the magazine and keep it for reference in your own office or facility.

I applaud the Colorado Health and Hospital Association for their efforts in aiding member hospitals as well as medical staff personnel. They beat us to the punch on this one, and rightfully so: the law was written primarily to regulate hospital/in-patient treatment. Physicians are certainly an integral part of this plan.

And I applaud the AMA Organized Medical Staff Section for providing the ***Quick Reference Guide for On-Call Physicians.*** This is a regulatory matter that certainly has not received enough attention. When we talk "regulatory," we are not necessarily talking "excellence in health care." Your very best scientific and humane skills just might not fit the regulations, so you must be aware of the regulations. I'm not saying that the regulations should change your scientific or humane skills; I am saying that the application of these skills must be in compliance with the regs, so you have to be aware.

You are urged to contact the local HCFA office for the complete EMTALA regulations, or contact your hospital medical staff attorneys. You will probably find that some member of your hospital administrative staff attended one of the CHHA seminars and can help you through the EMTALA regulations.

Letters

Archives

I just want to say that I thoroughly enjoy John Lightburn's articles in ***"Colorado Medicine"*** as I am sure a great many others do, each from their own perspective. Having worked closely with all of the presidents he has recently been profiling, - as he did - I can say that he certainly is giving credit where credit is due, and doing it in a most readable fashion.

Bob Bosworth, Denver

Professional Liability Insurance

Regarding your article about the history of Copic, I hope you will include the prehistory as alluded to in Jerome Buckley's "Copic Comment," (***Colorado Medicine,*** page 321, September, 2000).

CMS had an excellent malpractice program with Hartford Insurance Company. This was brokered by an insurance brokerage firm. In 1972, Bob Brittain and CMS Risk Management Committee received claims. I don't remember who was President when it started. I do remember its demise, which occurred when I was President.

It was when ITT acquired The Hartford Insurance Company and would no longer let us see its financial books; also, they insisted that we pay a bonus to the insurance brokerage firm. I objected strenuously and was one who felt we should form our own company, particularly in view of the work Bob Brittain and the committee had done.

Bill Curtis, Boulder

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Colorado Medical Society
130th Annual Meeting

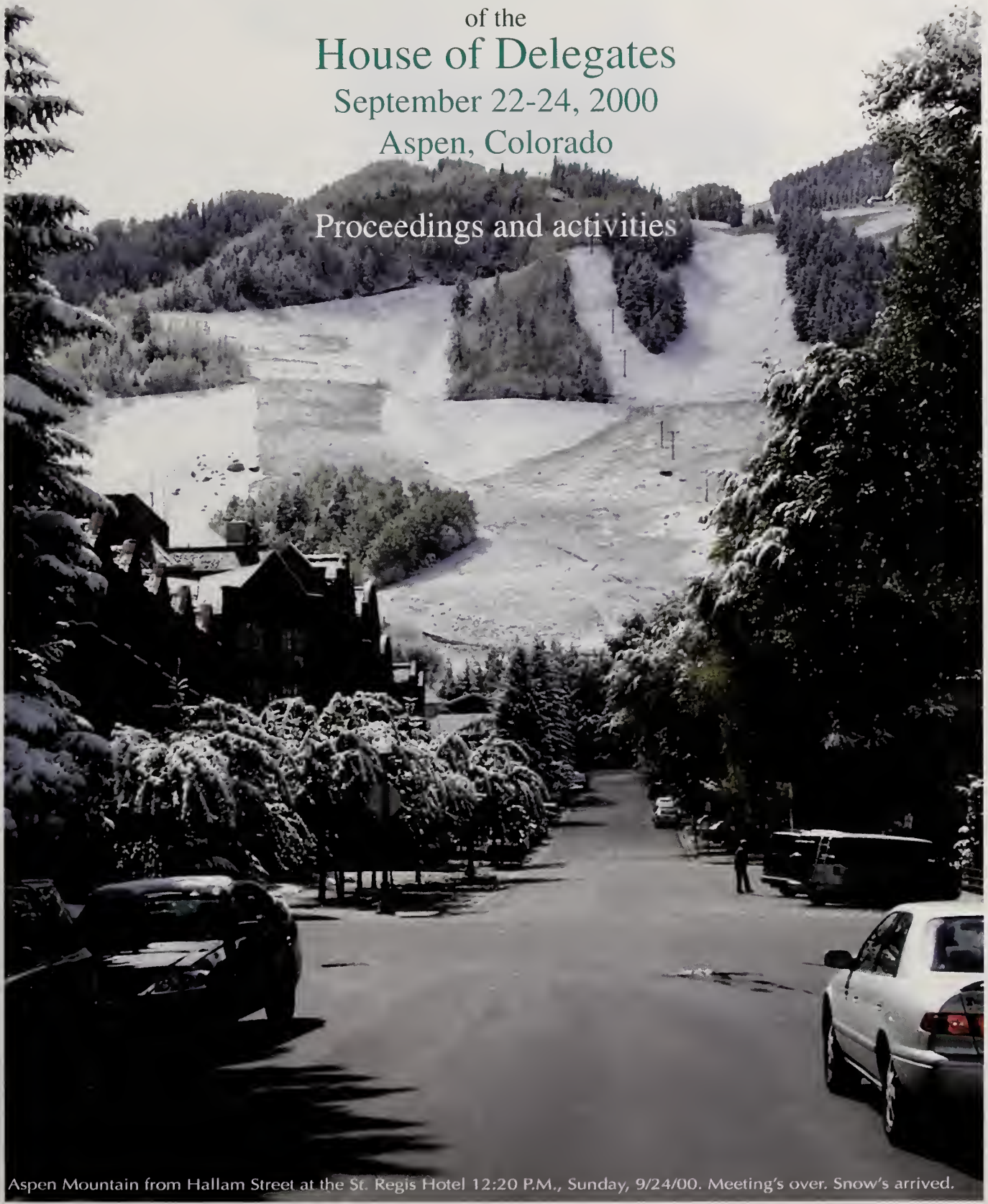
of the

House of Delegates

September 22-24, 2000

Aspen, Colorado

Proceedings and activities



Aspen Mountain from Hallam Street at the St. Regis Hotel 12:20 P.M., Sunday, 9/24/00. Meeting's over. Snow's arrived.

Space Snapshots

Robert N. Baker, MD
R. Neil Chisholm, MD
Leonard J. Farabaugh, MD
John A. Fleming, MD
Donald D. Hanna, MD
Harlan B. Huskey, MD
Joseph L. Kovarik, MD
Arnold B. Loken, DO
Gladys E. Martin, MD

Robert L. McKenna, MD
William J. Mellinger, MD
Maryethel Meyer, MD
Frits Mijer, MD
Robert L. Quimby, MD
John J. Sampson, MD
Henry W. Toll, MD
Stanley S. Weiss, MD

Hats Off! And a wave of congratulations and good cheer to the physicians listed here who have just become member sof the exclusive ***"Colorado Medical Society 50-Year-Club."*** These people completed schooling and received their medical degree 50 years ago this year.

We regret that only one of them was able to attend the CMS Annual Meeting this year to be recognized by the House of Delegates, but our sincere best wishes go out to them.



Joseph L. Kovarik, M.D., (right at left) of Littleton receives his 50-Year-Club membership from Vice-Speaker of the House Dr. Sherri Laubach. Dr. Kovarik was the only 50-Year physician who could attend the meeting this year. Dr. Kovarik, a former delegate to both the CMS and the AMA House of Delegates, is still active in the CMS House.



"2001: Medical Odyssey" theme decoration: He became known as "Doctor Rocket"

Getting Off on the Right Foot



"First Dance"
President & Mrs. Richard Allen

Global Glimpses



Louise McDonald, MD, 2000-2001 President-elect

Now & Then



Alliance "Poodles." CMSA meeting featuring '50s and their "Poodle" skirts.

Meeting Memories

Gone



Pat (Mrs. Richard) Allenreceives a gift at the "Gone But Not Forgotten" dinner. Atually, she just got here, as wife of the incoming President.

But



George Shanks, MD, on his retirement from the Board of Directors, receives a "thank you" gift, and gets a hug from Ms. Maloney. Dr, Shanks has served on the board since 1992.



Sandi Maloney with a gift from Dr. Jack Berry. The special made set of "table hardware" includes Sandi's family brand from their ranch in Montana, fashioned from horseshoes.

Not

Forgotten.



Maribeth and Jack Berry present gifts to Sandi Maloney, as Dr. Berry becomes Immediate Past President.



Bill Kaufman, Colorado Speaker of the House Pro Tem, addressed the COMPAC luncheon to an enthusiastic crowd.



Matthew Wynia, MD, of the AMA, speaking to physicians at the Educational program on Excellence in Medicine, and the necessity of watching your "professionalism." Dr. Wynia was extremely well received.



(Left to right) Marilyn Rissmiller, Sandi Maloney, and Edie Register, before the House of Delegates. Marilyn received a special award from CMS Executive Director Maloney for outstanding work on behalf of the CMS Hassle Factor Project. Her supervisor, Director of Health Care Financing Division of CMS, Edie Register, applauded the Hassle Factor Project and Marilyn's administering of the program. Edie and Sandi presented Marilyn with a certificate and a very generous gift certificate.

Future

Space.

The CMS Education Foundation awards to the winners of the Junior and Senior Medical Division of the Colorado Science Fair were made at the CMS House of Delegates meeting on Sunday, September 24th. Winners were invited to the meeting and to exhibit their winning projects. Junior winner was Lauren Neher of Brush, Colorado. Her family attended the presentation with her. The senior division winner was Benjamin Staub of Greeley. He and his mother, Hannah, were present for the presentation.

Each year, Colorado Medical Society gives the two winners a cash award of $100 each and a certificate. The CMS Education Foundation gives a cash amount to the Science Fair for continuation of its work in encouraging young people in their studies of natural sciences. The Fair is held at Colorado State University. Winners of county science fairs then participate in the State Science Fair. Approximately 400 students took part this year.

Colorado Medical Society physician members volunteer to judge the medical division. This year, Dr. Bill Kieger of Loveland and Dr. Jo Fletcher of Thornton served as judges. The CMSEF asks for three volunteer judges. If you are interested in participating in the 2001 Fair in April, please contact Sandy Finney, CMSEF Secretary/Treasurer, 720-858-6306 or 800-654-5653, ext. 6306.



Lauren Neher (2nd from right) receives her certificate and her award from Dr. Jack Berry. Looking on are (l to r) Dr. Bill Kieger, judge, Ron and Lila Neher, Rochelle and Shane Neher.



Dr. Berry (right) presents Benjamin Staub with his certificate and award. Ben was the senior winner of the medical division of the Colorado State Science Fair this year. Benjamin and his mother, Hannah, were presented to the House of Delegates by Dr. Bill Kieger (l) of Loveland, a volunteer judge for the Fair.

Future of Medicine



"Pair of Jacks" Jack Cletcher and Jack Berry, elected Alternate AMA Delegates.

Rob Bogin, M.D., (below) Chairman of the AMPAC Board of Directors, addressed the General Membership meeting. Dr. Bogin, a former Colorado Medical Society member, is now a resident of New Jersey where he practices part time. He is employed by Merck Pharmaceuticals.





Dr. Jack Berry, in his farewell address to the House, said his presidency was the highlight of his life, and he thoroughly enjoyed it all. He admitted that he would miss the activity, and wanted to stay on for a while (as an AMA Alternate Delegate). Dr. Berry said he was anxious to continue contributing his efforts to Colorado's organized medicine.



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HIGHLIGHTS OF THE BOARD OF DIRECTOR'S MEETING

Aspen, Colorado, September 21, 2000

I. ORAL REPORTS

A. Copic: Dr. Jerry Buckley introduced their new Chief Financial Officer, Mr. Steve Rubin. Copic will implement a new program soon called "The 3Rs Program". This program is a structured, patient-centered approach for addressing medical injury and complications in a way that preserves the physician-patient relationship.

B. AMA Delegation: Dr. Ray Painter expressed regret at the resignation of both Drs. Robert McCartney and Steve Thorson from their Alternate-Delegate slots but is looking forward to working with the new alternate delegates.

D. Medical Executives Group: Ms. Judie Watson stated that Ms. Sharon Rein would take over as Chair for the next year. Ms. Kathy Lindquist-Kleissler described what the MEGs have compiled so far from the Medicare Survey data. Ms. Marilyn Rissmiller of CMS was instrumental in the development of this survey. At this time, the MEGs have preliminary results only but hope to have further information soon and plan to have the results printed in **Colorado Medicine**. A brief discussion was held. These preliminary results will be forwarded to the CMS House of Delegates as an attachment to these minutes.

E. Colorado Physician Network (CPN): Dr. Martz reported that CPN is surviving and is working very hard to overcome its roadblocks. CPN is, however, continuing to increase its physician membership base. CPN has about 25,000 enrollees along the Front Range. Dr. Berry encouraged the CMS Board to continue support of CPN.

F. Colorado Medical Society Foundation: Dr. Bob Sawyer, Chair of the CMSF, reported that the presence of this foundation creates a good impression in the community. He expressed appreciation to the CMS Board for their continued support of the CMSF. The Coalition for the Medically Underserved conducted their third annual conference in March. Approximately 300 people attended this conference. The Colorado Rural Outreach Program (CROP) has continued to support many of the rural communities in Colorado with either physician retention or by supplying medical equipment. Dr. Sawyer thanked Ms. Maloney for her persistence in creating the CMSF. Ms. Anita Albrecht stated that the CMSF now has its own web site, which contains links to various shopping sites. The CMSF will receive a rebate for each purchase made from these sites. Dr. Berry thanked the CMS Alliance for their idea of the shopping sites.

G. Colorado Foundation for Medical Care (CFMC): Dr. Tom Dunn presented the report, pointing out the 30th anniversary of CFMC. CFMC has made great strides since its origination, and has made many changes to improve health care quality and utilization management, as well as assisted in decreasing medical error rates in Colorado.

Dr. Berry introduced Mr. Pat O'Rourke, Esq., CMS Counsel, and Dr. Andy Fine, new Board member for the Young Physician Section.

II. BOARD MEMBER REPORTS

Dr. Gene Sherman stated that the Aurora–Adams County Medical Society is working with the Denver Metro Presidents' Council to support educational public programs. He stated that the PacifiCare/Secure Horizons issue has once again created problems for physicians. He stated that PacifiCare had about 71 violations of Colorado State Law and the CMS White Paper by their actions in terminating physicians from their health care plan. They failed to notify the physicians but instead notified the physician's patients. The Colorado Revised Statutes state "each managed care plan shall allow covered persons to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice as specified in subsection (7) of this notice has not been provided to the covered person. Subsection (7) of the CRS states " A carrier and participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause. The carrier shall make a good faith effort to provide written notice of termination within fifteen working days after receipt of or issuance of a notice of termination to all covered persons that are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, all covered persons that are patients of that primary care provider shall also be notified. Within five working days after the date that the provider either gives or receives notice of termination, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier." This was admittedly an error on the part of PacifiCare. Dr. Gene Sherman requested that CMS notify the Colorado State Division of Insurance (DOI) and the National Council on Quality Assurance (NCQA), the Health Care Financing Administration (HCFA), and other appropriate entities.

MSC for CMS to forward the letter from PacifiCare that was sent to Dr. Gene Sherman terminating physicians from its managed care plan to the Colorado State Division of Insurance and to the Health Care Financing Administration, and if appropriate, after further investigation by CMS staff, forward the information to the National Council on Quality Assurance (NCQA). We will include in our comments that the method in which PacifiCare terminated several physicians from their health plan is at a minimum, in direct violation of Colorado Revised Statutes and the CMS White Paper (MOB-102-A).

III. PRIORITY ACTION ITEMS

A. Executive Committee

MSC, that based on the information received from legal counsel, the Executive Committee recommends that CMS not sign this Letter of Intent to participate in a relationship with HealthInsuranceSelect.com (MOB-104-A).

This matter will be referred to the Executive Committee for further study at its meeting on October 11, 2000. This issue will also be considered by the CMS Council on Ethical and Judicial Affairs before a final decision is made.

MSC to authorize staff to sign the appropriate documents for CMS' participation in the Merrill Lynch Managed Equity Program ("Consults"). Twenty-five percent of the current equity dollars will be placed in this program (MOB-108-A).

Dr. Berry provided three major reasons as to why the CMS Executive/Finance Committee made this decision and they are as follows:

- CMS is currently realizing a 10% gain in its stock portfolio, which is very good considering the current economic environment.
- The CMS Investment Policy was recently modified to increase the amount of dollars placed in the stock market to 40% (from 30%) and it is felt that adequate time be given to determine if

this amount is adequate.

- The CMS has an overall conservative posture in its investment policy because the dollars would when necessary, be use for contingency purposes, versus income production.

IV. COUNCIL ON LEGISLATION

Ms. Sandi Maloney reported that Suzanne (Hamilton) and John Tekrony are the proud parents of a beautiful baby daughter. All are doing very well. Ms. Maloney also reported that we currently have about thirty issues that are projected to be legislative proposals in the 2001 Session. Dr. Cletcher and Mr. Jerry Johnson reported on the results of the primary elections. Dr. Berry thanked Jerry Johnson for his tireless efforts on behalf of CMS and physicians of Colorado.

Division of Insurance Provider Risk Task Force – Review and Approve Alternative Mechanism Document

The Alternative Mechanism Document was presented by Dr. Ken Olds, Ms. Register and Ms. Maloney and reviewed in detail by the Board. Lengthy discussion ensued and Pat O'Rourke, CMS legal counsel, provided valuable input.

MSC to approve the draft document as written and to give authority to the CMS representatives on the Division of Insurance Provider Risk Task Force (Ms. Maloney, Ms. Register, Dr. Olds, and Dr. May) to pursue the regulation with highest priority given to consideration to individual physicians and to maintain the original intent of the draft document. Periodic status reports will be provided to the Board of Directors. Please reference Attachment 7-B for the draft report (MOB-109-A).

COLORADO MEDICAL SOCIETY

Delegate Attendance
130th Annual Meeting

Arapahoe Medical Society
Judy Baack, MD
Roy M Bartee II, MD
Max D Bartlett, MD
Barbara Chase, MD
Robert B Culberson, MD
William F Jessee, MD
Susan L Jolly, MD
Allan B Kortz, MD
Joseph L Kovarik, MD
Jeremy A Lazarus, MD
Mark A Levine, MD
Michael P O'Leary, MD
Vicki M Roe, MD
Karl Stecher Jr, MD
Richard H Stienmier, MD
Leigh Truitt, MD
Clara L Winter, MD

Aurora-Adams County
Edward M Canham, MD
Roderic D Gottula, MD
Angeline D Heaton, MD
Carl E Heaton, MD
Renu Jalota, MD
Richard G May, MD
Robert A O'Dell, MD
Susan A Sherman, MD
Barry R Sundland, MD
Christopher J Unrein, DO
Lawrence N Varner, DO
Paul B Visconti, MD

Boulder County
Jan F Baumgardner, MD
Gene E Bolles, MD
Steven T Chetham, MD
Daniel J Gerber, MD
Jonathan E Jensen, MD
Lori L Jensen, MD
Mark M Laitos, MD
Shannon P Pryor, MD
Scott L Replogle, MD
Nelson P Trujillo, MD
Patrick L Wherry, MD
Don E Wilson, MD

Clear Creek Valley
Richard L Brundige, MD
Chester M Cedars, MD
Kevin R Clemmer, DO
Richard S Cohen, MD
Ghodsi Daneshbod-Skibba, MD
William L Doig, MD
James S Gebhard, MD
John D Glismann, MD
Kathryn P Hebenstreit, MD
Mark B Johnson, MD
Jan M Kief, MD
William H Mendez, MD
Walter H Oppenheim, MD
H Manning Pickett, MD
Kathleen Y Sawada, MD
Michael A Volz, MD
Tracy M Wolf, MD

Colorado Chapter, American College of Emergency Physicians
Carla E Murphy, DO

Colorado Chapter American College of Physicians/Internal Medicine
Joel S Levine, MD

Colorado Child & Adolescent Psychiatric Society
Irvin A Ebaugh Jr, MD

Denver
Bonita S Carson, MD
Elinor T Christiansen, MD
Carlton M Clinkscales, MD
Robert P Dellavalle, MD
Donald G Eckhoff, MD
Richard H Glasser, MD
Herbert L Jacobs, MD
George E Kandel, MD
David L Kelble, MD
Jeannie J Kinzie, MD
Charles E Koftan, MD
Roderick G Lamond, MD
John L Lightburn, MD
Robert D McCartney, MD
Frederick N Meyer, MD
H Andrew Motz III, MD
Michael Muftic, MD
M Ray Painter Jr, MD
James R Regan, MD
Edward A Rhodes, MD
A Jason Richter, MD
Janet E Schemmel, MD
Elaine N Scholes, MD
Del Stigler, MD
Terrance J Sullivan, MD
Charles M Tuft, MD
H Dennis Waite, MD
Kim D Warner, MD

Eastern Colorado
John E Fox, MD

El Paso County
Arnold L Ahnfeldt, MD
Bradley G Beck, MD
Randall J Bjork, MD
John N Chatfield Jr, MD, MBA
Norman G Cole Jr, MD
Lewis A Crawford, MD
Tisha D Dowe, MD
William E Emeis, MD
Fred M Feinsod, MD
John H Genrich, MD
Bruce P MacHaffie, MD
George W Manning, MD
David C Martz, MD
Larry A Moore, MD
John B Muth, MD
Brian D Olivier, MD
Robert T Pero, MD
John L Sherman, MD
Teresa H Struck, MD
Stephen C Telatnik, MD
Michael D Welch, DO
Richard P Wetzig, MD

Fremont County
Caroline Rowlands, MD

Intermountain
Jonathan C Feeney, MD

Larimer County
Thomas J Allen, MD
Bruce R Belleville, MD
Cory D Carroll, MD
Michael P Curiel, MD
Laura A Hester, MD
A Bill Kieger, MD
Parker E Preble, MD
Floyd V Stephens Jr, MD
Robert J Tello, MD
P K Vedanthan, MD

Las Animas County
Douglas M McFarland, MD

Medical Student Component
Edwin Baca
Joseph E Dall'Era
Ramin Jamshidi
Mandy J Virant
Nathaen S Weitzel
Thomas P Worrall

Mesa County
Enno F Heuscher, MD
Bronwen J Magraw, MD
Robert A Sammons Jr, MD
Traci D Simms, MD
Frederic B Walker IV, MD

Mt. Evans
Marjie Grazi Harbrecht, MD

Mt. Sopris County
Ira S Jaffrey, MD
David Jacob Singer, MD

Otero County
James M Satt, MD

Pueblo County
Gary E Lane, MD
Alethia E Morgan, MD
Jarvis D Ryals, MD
Sharon K Schaefer, MD
Ernest W Steinle, MD
Robert E Tonsing, MD
Sara M Tonsing, MD
Jim R Valenzuela, MD

San Luis Valley
Richard L Brownrigg, MD
Raymond M Culp, MD

Weld County
Gary R Goodman, MD
Brian L Johnson, MD
Jerry A Nelson, MD
Kenneth M Olds, MD
Michael D Schwartz, MD
Roy H Shore, MD

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PROCEEDINGS OF THE HOUSE OF DELEGATES
Annual Meeting 2000

The Colorado Medical Society House of Delegates met at the St. Regis, Aspen Colorado, September 22-24, 2000 and took the following actions:

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Referred two Resolutions regarding insurance carrier responsibility to patients and physicians.

Adopted a Resolution requesting the Colorado Medical Society pursue legislation that states health plans cannot market physicians as members of their network without the written consent of the physician unless the physician is under signed contract 120 days prior to the effective date of the health benefit pay year.

Referred a Resolution requesting the Colorado Medical Society and the Colorado AMA Delegation work toward uniformity of the Current Procedural terminology (CPT) Coding system.

Referred a Resolution requesting the complete elimination of the Clinical Laboratory Improvement Act (CLIA) regulation of physician laboratories who perform only CLIA waived or provider performed microscopy procedures.

Adopted a Resolution requesting the Colorado Medical Society study the Hospitalist situation in Colorado.

Adopted a Resolution requesting the Colorado Medical Society seek legislation to make the inclusion of all-products clauses in managed care contracts an unfair trade practice.

Adopted a Resolution requesting the Colorado Medical Society support tuberculosis screening for active and latent infection of all individuals seeking to enter the United States. This Resolution also requests that the Colorado Medical Society educate their membership on the most effective methods of screening and treatment.

Adopted a Resolution requesting the Colorado Medical Society support the averaging of coding discrepancies above and below that supported by the medical record in arriving at an audit report of physician charging practices. This Resolution also requests that the Colorado AMA Delegation seek support of a similar concept at a national level.

Adopted a Resolution requesting that the Colorado Medical Society encourage the development of educational materials and a test procedure for the Colorado Limited Scope radiology examination.

Adopted a Resolution requesting the Colorado Medical Society endorse the passage of the ballot initiative **26.1** : **Background Checks - Gun Shows**.

Adopted a Resolution to approve the recommendations of the Gun Related Mass Assault Task Force.

Adopted a Resolution requesting the Colorado Medical Society support legislation to establish an electronic statewide immunization tracking system or registry.

Adopted a Resolution to amend and expand upon the Colorado Medical Society's current policy "Canceling Subscriptions to Magazines that Advertise Tobacco Products"

Adopted a Resolution to sunset current Colorado Medical Society policy on the "AMA Guides to the Evaluation of Permanent Impairment", and to replace with new language stating the Colorado Medical Society supports adoption, by the appropriate regulatory agencies, of the most recent edition of the "AMA Guides to the Evaluation of Permanent Impairment".

Accepted for filing:

Progress Report - Council on Legislation
Progress Report - COMPAC
Progress Report - Colorado Medical Society Foundation
Progress Report - Health Affairs Council

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS/CREDENTIALS

Adopted a Resolution to amend Colorado Medical Society Bylaws to clarify membership classifications.

Referred a Resolution amending Colorado Medical Society Bylaws to allow membership for allied health professionals.

Adopted a Resolution requesting the Colorado Medical Society survey residents, young physicians and women physicians to determine interest in establishing/maintaining the respective sections. If these sections do not meet Bylaws requirements by October 1, 2001, they will be sunset and no longer entitled to hold a seat on the Board of Directors or in the House of Delegates.

Adopted a Resolution to create a task force that will formulate a proposal that will help strengthen organized medicine and promote collaborative efforts between the Colorado Medical Society and its component societies.

Adopted a Resolution requesting the Colorado Medical Society to encourage physicians to attain and use knowledge of palliative medicine and to encourage patients to consult with their physicians about the appropriateness and availability of palliative care.

Adopted a Resolution to amend the policy on the ethics of Euthanasia and physician-assisted suicide.

Adopted a Resolution requesting that the Colorado Medical Society investigate the request and use by hospitals, other credentialling and privileging entities, and other similar entities of medical records releases for physicians' individual medical records.

(Continued)

Adopted a Resolution asking the Colorado Medical Society to respond to the Board of Medical Examiners' request for assistance on guidelines regarding office-based surgery and anesthesia. In addition, the Colorado Medical Society should review, study, and develop a policy related to all non-hospital-based surgery and anesthesia.

Adopted a Resolution calling for the Colorado Medical Society to oppose the 2000 ballot initiative known as Tabor 205. This ballot initiative, if passed, would have negative effects on the emergency medical services and hospital districts, which could create a public health crisis.

Adopted a Resolution allowing members of the Board of Directors voting privileges in the House of Delegates.

Adopted a Resolution allowing the Speaker and Vice Speaker of the House of Delegates voting privileges on the Board of Directors.

Adopted a Resolution to reaffirm CMS Bylaws Chapter V, "Board of Directors".

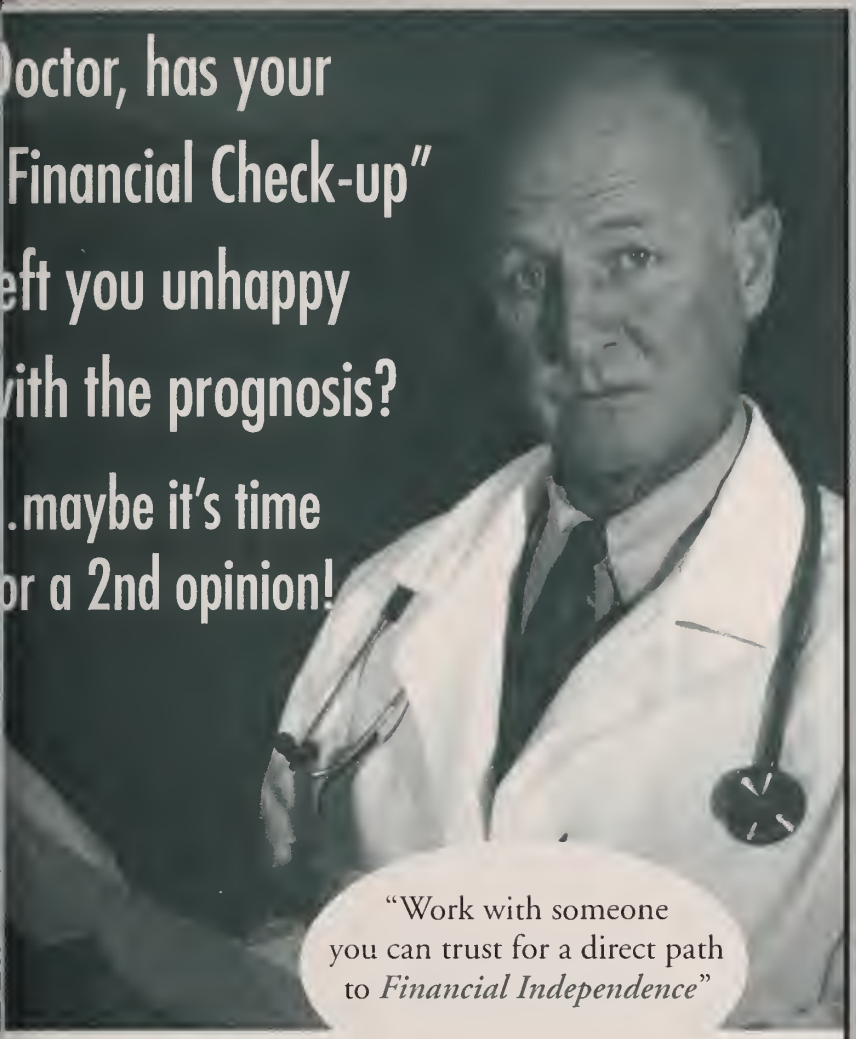
Accepted for filing:

Progress Report - AMA Delegation
Progress Report - Board of Directors
Progress Report - Council on Ethical and Judicial Affairs
Progress Report - Executive Director
Progress Report - CMS Education Foundation
Progress Report - Organizational Study Committee



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Program

Friday

7:45 AM	Continental breakfast
8:30	Welcome by George Shanks, MD
8:45	Plenary One "Gaps, Models and Goals in End of Life Care" Bruce Richards, MD
9:45	Transition Break
10:00	Module One "Advance Care Planning" Bruce Richards, MD and Phil Engen, MD
11:00	Break
11:15	Module Two "Communicating Bad News" David Nowels, MD, MPH, and Jean Kutner, MD
12:15 PM	Lunch
1:30	Module Three "Pain Management: Assessment, Building Blocks to Optimal Pain Management" Phil Engen, MD, and Jean Kutner, MD
2:30	Break
2:45	Plenary Two "Advance Care Planning 101: Important Legal Doctrines" Susan Fox, JD
3:45	Open discussion by Pat Moran, MD/Panel
4:30	Adjourn

Saturday

7:45 AM	Continental breakfast
8:30	Module Four "Whole Patient Assessment and Common Physical Symptoms" Jean Kutner, MD, and David Nowels, MD, MPH
9:30	Break
9:45	Module Five "Sudden Illness" Phil Engen, MD and Jean Kutner, MD
10:45	Break
11:00	Module Six "Medical Futility, Withholding and Withdrawing Treatment" David Nowels, MD, MPH, and Phil Engen, MD
12 noon	Closing by Bruce Richards, MD

New Members

Congratulations and welcome to these newly elected CMS members

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David R Conway, MD
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David H Dungan, MD
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Jamie B Houg, MD
William F Jessee, MD
Terese Kaske, MD
John P Kepros, MD
Frank S Kopich, MD
Steven P Lawrence, MD
Ethan A Lazarus, MD
Eric S Malden, MD
Sunil Nayak, MD
Nicholas G Nonas, MD
Nathan R Olsen, MD
Michael T Otte, MD
Jill E Pechacek, MD
Mark A Perea, MD
Angie G Poturalski, MD
Ray T Rupel, DO
Susan L Tiegs, MD
Dominic C Yee, MD

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Mark E Dixon, MD
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Mark H Nathanson, DO
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Summer R Teruya, MD
Curtis L Waln, MD

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David J Musnick, MD
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Mary B Poole, MD
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Victor A Shada, DO
Audrey L Sheridan, MD
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Thomas E St Amour, MD
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Michael J Wright, MD

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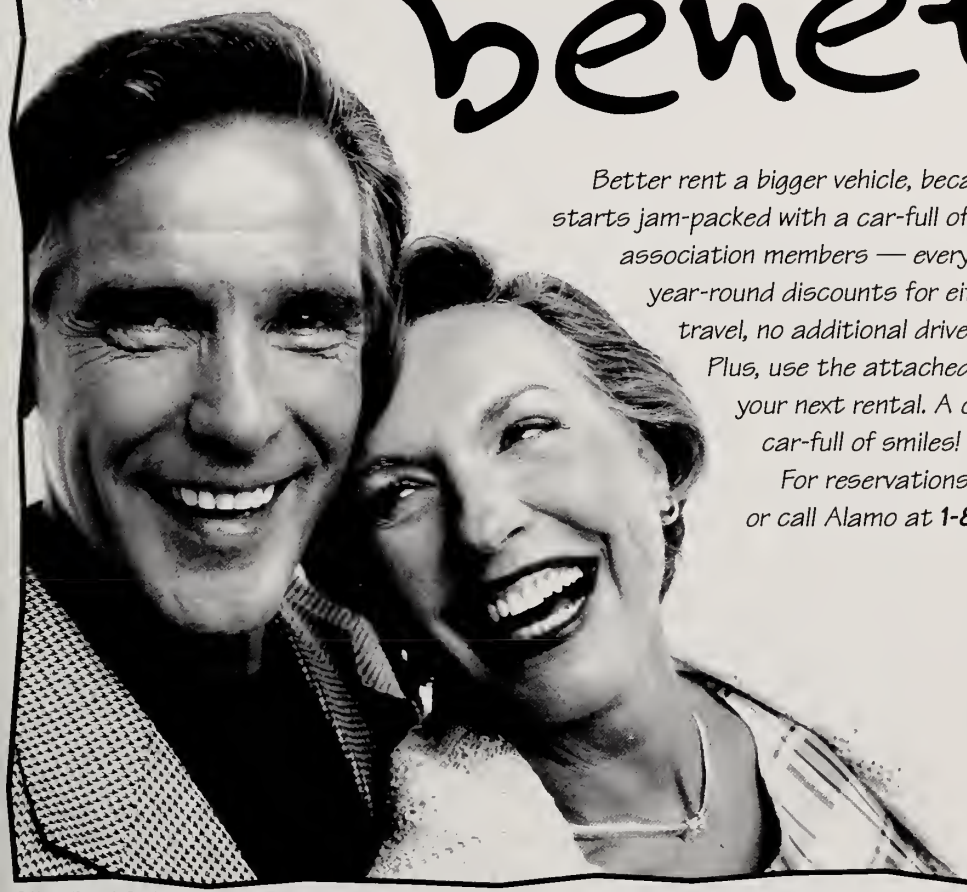
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In Memoriam

Lynwood M. Hopple, M.D., age 80, a lifelong Colorado resident, died Sept. 1, 2000, at Montrose.



Born in Colorado Springs, Colo., on July 2, 1920, Lynwood M. Hopple graduated from Colorado College in 1942 and the University of Colorado Medical School in 1945. He was in the U. S. Navy V-12 program from 1943 to 1945 and was on active duty from 1945 to 1948.

Married to Lois Shafer on Dec. 6, 1947, he then completed his residency at the Colorado Psychopathic Hospital in Denver, specializing in psychiatry and electroencephalography

Dr. Hopple was an instructor of psychiatry at the University of Colorado School of Medicine from 1951 to 1952. He was the first director for the Division of Mental Health in the Colorado State Health Dept. from 1952 to 1960 and was instrumental in establishing and developing 21 rural mental health clinics throughout the state. He received numerous awards for his service and contributions to psychiatric mental health in Colorado. He also spent time abroad with the 1962 medical team of the S. S. Hope ship in Peru. Dr. Hopple was an active pilot attaining an airline transport rating. He was an flight instructor and flew teams of physicians and mental health practitioners to rural Colorado mental health centers. He was a Life Fellow of the American Psychiatric Association, Director of the Flying Physicians Association, Life Member of the Christian Association of Psychological Studies and a Distinguished Member of the Western Association of Christians for Psychological Studies. He was an active member of the Colorado Medical Society, Curccanti Medical Society, and the American Academy of Family Physicians.

A devoted Christian. Dr. Hopple served his church, family and friends as a mentor and supporter. He was a member of Gideons International. He is survived by his wife, Lois, of Montrose, two daughters, Jacquelyn Hetherington, of Albuquerque, N.M., and Janice Clack of Ft. Collins, their husbands and two grandchildren.

Interment was in the Ft. Logan National Cemetery at Denver.

William Clinton White, M.D., Col. U. S. Army Medical Corps (Ret.), died June 22, 2000, in Pensacola, FL.

Born in Scottsville, Virginia, November 11, 1911, he was a graduate of Virginia Military Institute and the University of Virginia Medical School. During World War II he served in the Surgeon General's Office and Commanded the 35th Field Hospital in North Africa and Italy. Following the war he became Medical Director, Los Alamos Hospital, Los Alamos, NM.

A long time resident of Denver, he was Resident in Pathology at the University of Colorado Medical Center from 1949 to 1952 and served on the Faculty from 1952 to 1965. He was Chief of Laboratories at Denver General Hospital from 1952 to 1965. He played a major role in the administration and development of the hospital during Denver General's evolution. Those who worked with him say he had great leadership qualities and skillfully administered the Pathology Department and medical laboratory needs during those years.

Moving to Pensacola, Florida, in 1985, he served as the first Director of Medical Education, Pensacola Foundation for Medical Education and Research and on the Florida Board of Regents. His many contributions and accomplishments are featured in *Marquis "Who's Who in the South and Southwest", "Who's Who in America"* and *"Who's Who in the World."*

He is survived by his wife of 63 years, Frances Evelyn Daniel White, a son and a daughter.

In Memoriam

A tribute

Maxwell A. Abelman, MD
April 26, 2000
Thomas J. Arganese, MD
May 12, 2000
H. Kent Axtell, MD

Gilbert Balkin, MD
May 20, 2000
David E. Bates, MD
March 30, 2000
Richard A. Bell, MD
November 23, 1999
Floyd Bjork, MD

Jack C. Booren, MD
March 10, 2000
R. Robert Cohen, MD
December 27, 1999
D. Eugene Cowen, MD
May 12, 2000
Arlo R. Edmundson, MD

Daniel E. Gelfand, MD
December 13, 1999
Harold E. Gilman, MD
December 12, 1999
John B. Griffith, MD
May 2, 2000
Thomas F. Jacques, MD
June 13, 1999
George D. Jones, MD
September 21, 1999
James C. Lombardi, MD
May 15, 1999
Kenneth M. Matchett Jr., MD
November 14, 1999

Herman S. Maul, MD
May 25, 2000
Joseph J. McGill, MD
April 3, 1999
Stuart A. Patterson, MD
April 28, 2000
Elmer B. Pratt, MD
September 16, 1999
Aaron B. Pretsky, MD
June 6, 2000
Paul H. Rhodes, MD
March 16, 2000
Robert B. Richards, MD
June 3, 1999
Aloysius Rowen, MD

Leroy J. Sides, MD
October 31, 1999
Chester Stevenson, MD

William Y. Takahashi, MD
May 26, 2000
George W. Thatcher, MD
November 21, 1999
Wesley Vancamp, MD
February 16, 2000
Martin G. Vanderschouw, MD

Eli R. Wayne, MD

William P. Wilz, MD
August 18, 1999

John L. Lightburn, M.D.
Historian
Colorado Medican Soiety



The "Great Society" And Beyond

"I urge you to give priority to those functions of our Society which relate to the welfare of our state and communities, and to subordinate, where possible, those functions which are more directly self-serving."

William M. Covode, M.D.
in his Inaugural address, Sept. 13, 1968

The 1960s may be remembered by many of us for Lyndon Johnson's "Great Society" and the travail of our country's involvement in Viet Nam. The anguish and pain of those days still influences our country's response to the world. But there were several events of the sixties that had a more direct effect on the practice of medicine. For example, on May 9, 1960, the Food and Drug Administration announced the approval of the first birth control pill. What a liberating event that was for millions of women. It was the beginning of the "women's movement" or the women's liberation. This was followed by marches in Washington and New York and the call for equal rights and even the legalization of abortion! With great fanfare, Congress passed the Equal Rights Amendment. Although the amendment was never ratified by the required number of states, the women's movement set in motion dramatic changes in our society and especially in our profession. In several states, legislatures passed laws legalizing abortion. In Colorado, the legislature passed such a bill. It had been authored and introduced by a young representative from Denver, Richard Lamb. No longer would young women have to sneak up to Rawlins, Wyoming to terminate an unwanted pregnancy. More important to the medical profession was the increase in the number of women entering medical school. For most of us men, that was a welcome and needed change in our profession. With this background, let us see how CMS fated in the late 1960s.

Paul R. Hildebrand became our 96th CMS President in 1965. He was chosen by the House of Delegates to take the place of Lawrence D. Buchanan, a general practitioner from Wray. Dr. Buchanan was president-elect but had suffered a myocardial infarction just a few weeks before he was to assume office. So Paul Hildebrand, a soft spoken, mild mannered general practitioner from the small town of Brush, assumed the presidency without the usual preparation, and he assumed office at a very hectic time. This was the year that the nation's most skilled politician, Lyndon Johnson, pushed through his "Great Society" program which included Medicare and Medicaid. When Congress had finally sent the Bill to the White House for his signature, President Johnson took the Bill to the Truman Library in Independence, Missouri, where he signed it into law with Harry Truman standing at his side. Liberals had been trying to get a National Health Insurance Plan through Congress ever since Harry Truman had been President. President Johnson finally rammed it through a reluctant Congress. Passed into law in 1965, the Medicare law became operative on July 1, 1966. This was in the midst of Paul Hildebrand's term and his colleagues in the CMS were in an angry and rebellious mood. Most of the CMS members had bitterly opposed passage of that law and their bitterness mounted in late 1965; many announced they would refuse to participate. Paul Hildebrand had personally opposed any governmental intervention in private medical practice. But this wise and patient general practitioner urged his colleagues to observe and live with the new law. In his talks to component societies, he told his fellow physicians to maintain the highest quality of medical care in spite of this new participant in the health care system. His years of private practice and leadership in his own community had given him the wisdom and patience to guide the society through these troubled times.



Paul R. Hildebrand, M.D.

(Continued)

Our 97th CMS president was Myron C. Waddell, chief of the Ob-Gyn service at Denver's Presbyterian Hospital. If he was troubled by Medicare, he did not reveal it in his published papers. His overriding passion was the education and welfare of the young people of the



Myron Waddell, M.D.

state. In 1962, he established the Colorado Health Careers Council, financed it anonymously, persuaded the CMS to sponsor it and house it in the CMS office building. Soon, other medical societies and allied health professions joined the council and it became a fully chartered, tax exempt organization steering bright young people into the health professions.

He co-founded in 1969 the annual CMS Seniors Day for the C.U. graduating medical class. As CMS president, he directed Colorado's first participation in the Amigos de las Americas which annually sent teams of selected youth under medical supervision to Central and South America where they helped the people in small native villages by teaching sanitation, modern health practices and providing immunizations. This was a wonderful alternative to the rebellious drug culture of those years when "hippies" were spacing out on LSD, pot and other illegal drugs. Eventually, civil unrest in Latin America made it unsafe to send young people to those countries, and the program was discontinued.

Myron Waddell was a jovial, optimistic guy whose smiling face persuaded many busy men and women to participate in volunteer programs for the CMS and other community activities. He grew up in Nebraska, was graduated from the medical school at Duke University in 1934. He first came to Denver for internship and ob/gyn residency at Presbyterian Hospital. After a year in academic medicine at George Washington University, he returned to Denver to become one of the bright stars in our medical community.

CMS 98th President was Henry J. Zeigel, a general practitioner from Collbran, a town of about 200 people on the slopes of Grand Mesa. In the sixties, physicians were still a well dressed profession as they went on their hospital rounds and saw patients in the office. But not Dr. Zeigel. Like his fellow citizens of Collbran, he generally wore boots, weary but clean trousers, flannel shirt, jacket, looking very much like a rancher.



Henry J. Zeigal, M.D.

He was a stubborn disciplinarian in his office and his 17 bed hospital, the Plateau Valley Congregational Hospital. When Medicare became an important source of funding for small, rural hospitals, an official inspection discovered that the hospital building did not meet the requirements of the health department or the HCFA. Guess what? The hallways were too narrow! It would have required prohibitively expensive remodeling to bring the building into compliance. His tenacity and resourcefulness saved the hospital for his little community. With convincing logic he won the support of the medical societies, the AMA, the health departments and eventually the U.S. Congress so that his hospital and many other small town institutions could continue to serve Medicare patients. He demonstrated how to participate with the Medicare plan without sacrificing the interests of his patients. What was amazing about Henry Zeigel was that he could fulfill his responsibilities as President of CMS and still carry an his solo practice as the only physician in Collbran. He delighted his colleagues in the CMS when he fought "city hall" (the Social Security Administration) and won! Maybe Paul Hildebrand was right; be patient and persevere.

When the House of Delegates chose William M. Covode to be our 99th President (1968-69), they may not have known how liberal this genial urologist was, or perhaps they had experienced a remarkable change of heart or maybe they found him so likable they could not vote against him. Although Dr. Covode's predecessors had reluctantly recognized that change in medical practice was inevitable and had urged the CMS to modify their uncompromising opposition to any government programs, it was Bill Covode who really took the bull by the horns and aggressively forced new, highly progressive modern thinking into the society's socio-economic activities.



Wm. M. Covode, M.D.

His "Inaugural Address", delivered at the CMS Annual meeting on September 13, 1968, in Colorado Springs, was a shocker! He was an eloquent speaker and challenged his colleagues. He said he was humbled by the "mystery" of

(Continued)

his election, especially since there had been no platform, no evocation of his political philosophy. He continued "I now offer a few items for your consideration and I hope your review will be sympathetic".

Referring to the turmoil in our country, "These are anxious times. . . . .the plight of our Nation should be, at this moment, the greatest concern of every citizen. . . . the American Dream is not being fulfilled. . . We have lived complacent and established, confident that the noble statements in our Constitution and The Rill of Rights were implemented. The size and complexity of our society has led us to seek security in smaller and smaller groups, to consider questions of lesser and lesser magnitude, while around us the fundamental issues grew and grew. We concerned ourselves with Communism and Socialism and forgot to worry about Democracy. . . It is too late for the unrestrained and bitter debate of the extremists that suppresses positive action and leaves the moderate man without leadership. ...Unless the compelling moral, social, and economic problems are solved, what happens in the lesser issues is of little consequence." He went on to say that he agreed with the concept that comprehensive health care is a basic right and he regretted that the concept has not originated with the American Medical Association.

Not only did he challenge the CMS in his presidential address he openly welcomed the Kaiser Permanente Foundation to Colorado. Indeed, he gave strong support to his colleague, Bill Riemers, who was the first Medical Director. Dr. Riemers had received considerable abuse and criticism for promoting such a radical concept. Perhaps more radical was Bill Covode's support of government sponsored neighborhood health clinics.

Even those who opposed his position about the government involvement in medicine found themselves listening whenever he spoke and reading whatever he wrote. He was a master at public speaking and a persuasive writer. Every speech and Presidential letter sparkled with knife-sharp wit and phraseology. Although many had considered him "too liberal" or "too damned radical", almost all were applauding his proposals before his term as CMS President had ended.

Dr. Covode was born in Pennsylvania, raised in Florida, received his MS and MD from the Northwestern University and completed his internship and genitourinary residency at Cook County Hospital. He had a lovely home one block east of Cheeseman Park where he spent many relaxing hours in his rose garden.

John M. Wood followed Dr. Covode as our 100th President, 1969-70. Those two wonderful men met the challenges of the late 1960s with almost identical philosophies and goals; but they were different in their approach to the office of President. John Wood was a less charismatic speaker but was a problem solver and master organizer. He has been considered the father of the Colorado Foundation for Medical Care (the CFMC is celebrating its 30th birthday this year; more about that in a future issue). Both Arapahoe



John M. Wood, M.D.

County and Denver Medical Societies had established a metropolitan area foundation, but John Wood insisted that there should be a state wide foundation. When he became President -elect, he worked hard for two years to organize the foundation. His many hours of skilled planning and organizing resulted in the incorporation, funding and beginning operation of the foundation. Here was an effective peer review organization under the direction and control of physicians. To accomplish this task, he spent heavily of his own time and money, even refusing the honorarium the CMS usually accords its Presidents.

His interests were not limited to the Foundation. He promoted multiphasic testing for better preventive medicine; he asked for expanded peer review mechanisms in hospitals and specialties; he organized better communication between CMS councils, committees and component societies. And he wanted better communication with non-member physicians.

He reacted immediately and decisively to problems. For example when the news media reported that a hearing of the U.S. Senate Finance Committee revealed that a single Colorado physician had received $326,000 in fees under Medicare-Medicaid in a single year, Dr. Wood discovered that the payment was for the work of the entire staff of Colorado General Hospital and quickly insisted on a retraction from the Committee and the news media. An apology was given, reluctantly because it had been a sensational story.

During World War II, John Wood spent four years as a Chief Pharmacists Mate in the U.S. Navy. In 1945, he began his premedical studies at the University of Denver and was graduated from the University of Colorado School of Medicine in 1951. He completed his residency in pathology at Colorado General Hospital. Since 1959, he was Director of Pathology at Swedish Hospital and the Director of Cytotechnology at C.U.'s medical center. He was on the Greenwood Village city council for four years and was mayor for two years.

Like many of the preceding Presidents, Dr. Wood was a dedicated physician, selfless in his work for his profession and his community.

As I have learned and written about these men, I've realized how privileged I have been to be a member of our profession.

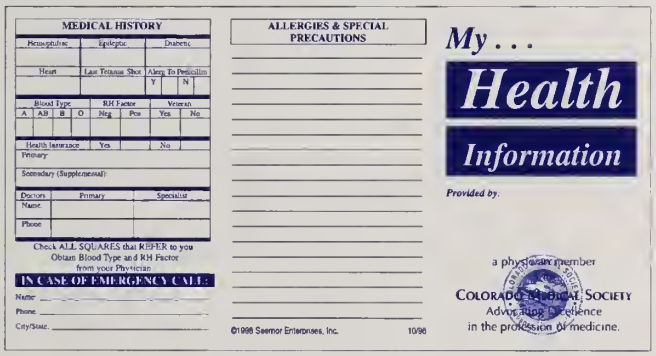
Are your patients fully aware of their medications?

How do your patients remember what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions. That's a lot to remember, but here's a way to help them.

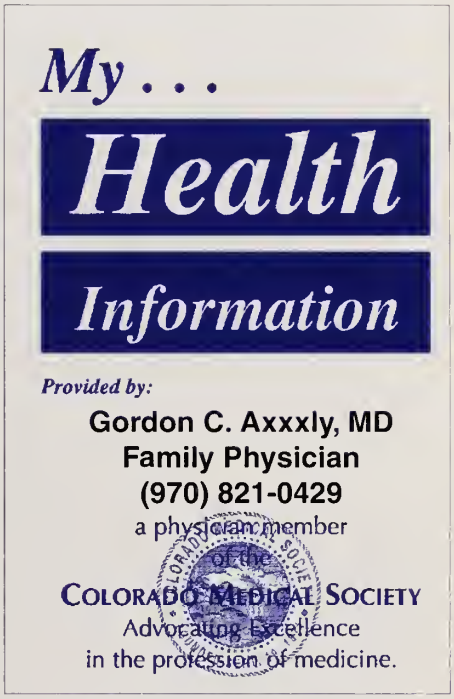
Every day you remind your patients to follow your directions exactly. Even so, we hear of patients taking seriously conflicting substances, such as using an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among older citizens.

Here is a device you can give your patients which will help them remember their current medications , the dosage and the schedule. It is a handy, pocket-sized card which is constructed of sturdy plastic. . . and the card can be written on if the prescriptions change.

The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as the medical needs change. The card will hold up a long time.



1/2 of actual size



Actual size of folded card

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We at CMS feel that your patients will appreciate you for providing them with this, and will be a constant reminder of the quality of care and concern you have for their healthy well-being.

These cards are inexpensive; they can be ordered in lots of 100 @ $0 .40 ea = $40.00

200 @ $0.36 ea = $72.00

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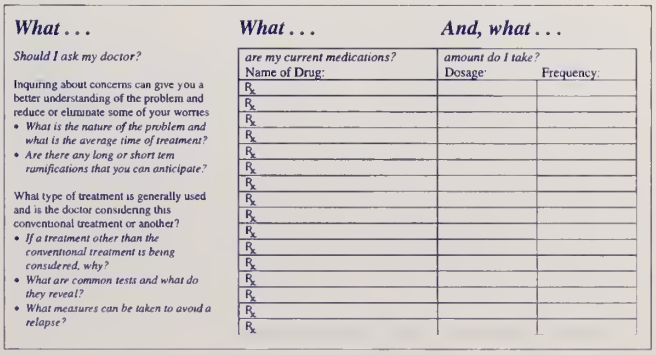
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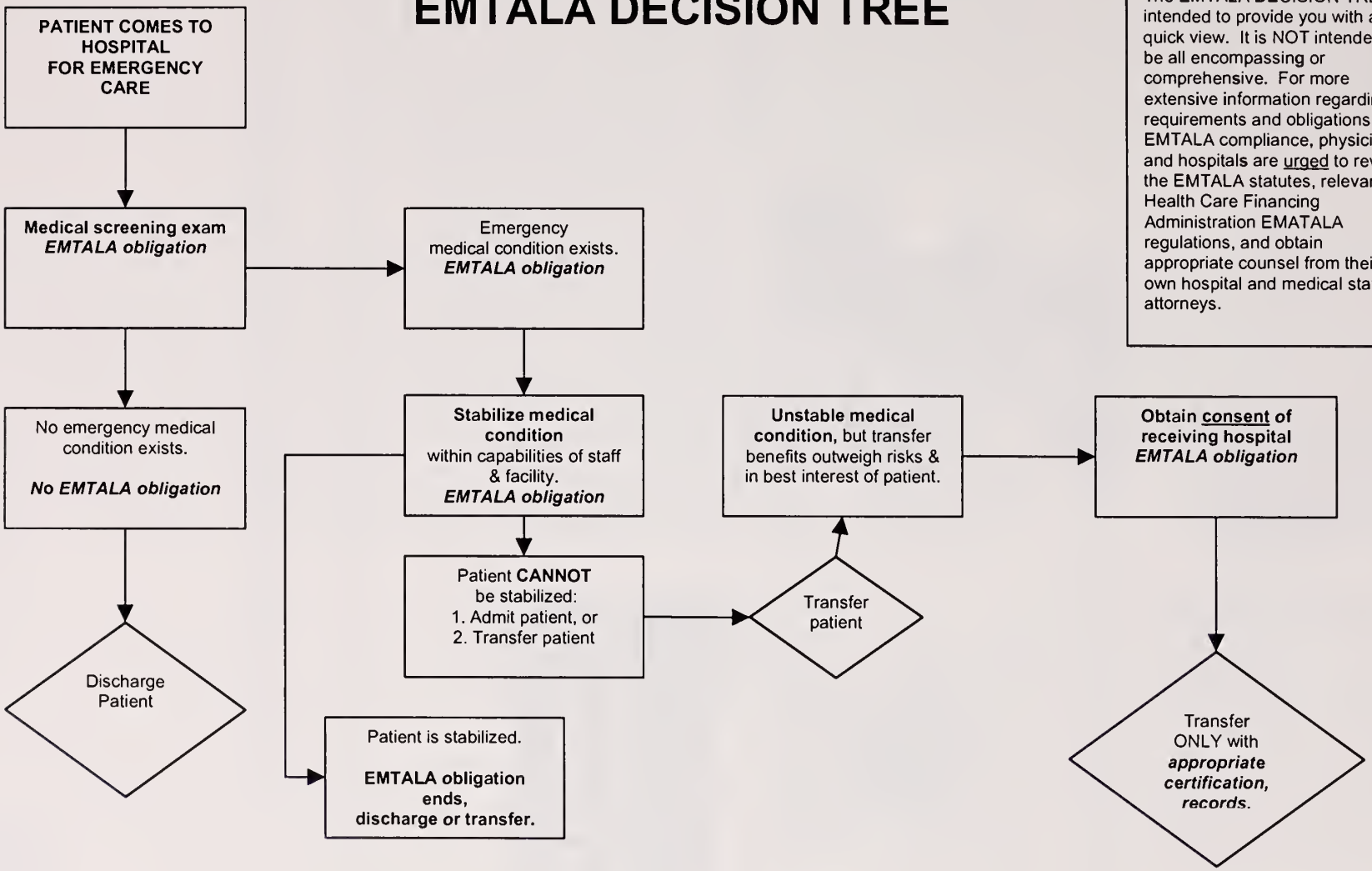
Delivery will be within the week.



1/2 of actual size

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EMTALA DECISION TREE



The EMTALA DECISION TREE is intended to provide you with a quick view. It is NOT intended to be all encompassing or comprehensive. For more extensive information regarding requirements and obligations for EMTALA compliance, physicians and hospitals are urged to review the EMTALA statutes, relevant Health Care Financing Administration EMATALA regulations, and obtain appropriate counsel from their own hospital and medical staff attorneys.

EMTALA
QUICK REFERENCE GUIDE
FOR ON-CALL PHYSICIANS

This EMTALA Quick Reference Guide is intended as an abbreviated summary of what is expected of on-call physicians. It is NOT intended to be an all encompassing or comprehensive discussion of EMTALA. For more extensive information regarding requirements and obligations for EMTALA compliance, physicians and hospitals are urged to review the EMTALA statutes, relevant Health Care Financing Administration (HCFA) EMATALA regulations, and obtain appropriate counsel from their own hospital and medical staff attorneys.

What is the Emergency Medical Treatment and Active Labor Act (EMTALA)?

EMTALA is the federal "anti-dumping law" enacted by Congress in 1986 to assure that patients who come to hospitals for treatment of an emergency medical condition are not turned away or transferred to another facility, based on their ability to pay. It applies to any patient who seeks care, whether the patient's access is through the emergency department or any other department of the hospital.

What are the responsibilities of hospitals and what treatment and services must be provided to be in compliance with EMTALA?

I. Provide an appropriate medical screening examination to all individuals seeking emergency services to determine the presence or absence of an emergency medical condition either by a physician or other qualified medical personnel as specified in medical staff bylaws, rules and regulations, or policy and procedures.
II. Stabilize the medical condition of the individual, within the capabilities of the staff and facilities available at the hospital, prior to discharge or transfer.
    A. Obstetrical patients with contractions are considered unstable until delivery of baby and placenta.
III. An unstable patient cannot be transferred unless the patient (or a person acting on his or her behalf) requests the transfer or the transferring physician certifies in writing that the medical benefits of the transfer, outweigh the risks, and is in the best medical interest of the patient.
    A. Stabilize within the hospital's capabilities to minimize the risk of the transfer.
    B. Obtain the acceptance of the receiving hospital.
    C. Send all pertinent medical records available at the time of the transfer to the receiving hospital.
    D. Effect the transfer through qualified persons and transportation equipment (including life support measures)
IV. A receiving hospital, with specialized capabilities, must accept a patient transfer unless that acceptance would exceed its capability and capacity for providing care.
V. Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time.
VI. The hospital must provide the name and address of any on-call physician who refused to respond or failed to make a timely response, along with the transfer records, of any patient transferred as a result of that refusal or lack of timely response. Prior to screening and stabilization, the hospital emergency department may follow normal registration processes, as long as they ***do not delay care,*** and prior authorization is not received before screening or commencing stabilizing treatment is allowed.
VII. Conspicuous signage must be posted in the emergency department stating the rights of individuals under EMTALA and whether the hospital participates in the Medicaid program; and also maintain a 24 hour/7-day (24/7) on-call schedule of physicians taking call for the emergency department.

What is an on-call list?

An on-call list is a roster of physicians providing the date and time when those physicians are scheduled to respond to the hospital to provide evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. The on-call list must include specialists and sub-specialists routinely available to the Emergency Department. Hospitals may establish a reasonable on-call schedule other than 24/7 if they are unable to secure agreement by physicians to take call round-the-clock because of the dearth of specialists in the area.

I. The on-call list is maintained by the hospital and medical staff and must be immediately updated to reflect any changes in physician staffing.
II. Physicians whose names appear on the on-call list are responsible for finding a suitable replacement if they cannot be available for duty and for updating the on-call list with the replacement physician's name and other appropriate information.

Which medical staff documents define the responsibilities of on-call physicians?

I. The medical staff bylaws, rules and regulations, or policies and procedures should define the responsibility of on-call physicians to respond, examine and treat patients with emergency medical conditions.
II. The medical staff and hospital should have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

What are the responsibilities of on-call physicians to be in compliance with EMTALA?

I On-call physicians **MUST** respond to the hospital when requested to attend to patients in a timely manner and complete a medical screening examination or provide stabilizing care. *HCFA has not set a specific rule for response time, but some HCFA officials have mentioned 30 minutes.*
II The transferring physician **MUST** discuss the case with the receiving hospital's authorized representative and obtain agreement to accept the patient in transfer. (All hospitals with specialized capabilities, including physician specialists, have a responsibility to accept a transfer when such transfer is necessary to stabilize an emergency medical condition .)
III. On-call physicians, who may be on-call at another hospital, simultaneously, **MUST NOT** request that a patient be transferred to a second hospital for the physician's convenience.

On-call physicians who, as part of their routine responsibilities, are charged with the duty to accept patients transferred from other facilities, may not refuse any unstable transfer as long as their hospital has the capability and capacity to provide treatment.

Can an emergency patient be sent to the office of an on-call physician for the medical screening exam and stabilization?

No, not unless the on-call physician's office is located in a hospital-owned building which is contiguous or located in a hospital-owned building that is "on campus" and the service must be billed under the hospital's provider number[1] .

A patient can be transferred to a physician's office IF, the physicians' office has specialized equipment and capability that the transferring hospital does not have. The transferring physician must certify that the medical benefits of the transfer outweigh the risks and it is in the best medical interest of the patient. Under no circumstance should a patient be transferred for the convenience of the physician.

What are the possible penalties or sanctions for EMTALA violations?

Medicare-participating hospitals and physicians found to be in violation of EMTALA could be sanctioned as follows:

I. Termination of the hospital and/or physician Medicare provider agreement.
II. Imposition of civil monetary penalties against the hospital with 100 or more beds of $50,000, per violation. The fine per violation for hospitals with less than 100 beds cannot exceed $25,000.
III. Civil monetary penalties for physicians can be up to $50,000 per violation.
IV. On-call physicians responsible for examination, treatment, or transfer of an individual are subject to potential civil fines of up to $50,000 per violation for failing to come to the hospital, and may be excluded from Medicare.
V. "EMTALA provides a private right of action against a hospital for an EMTALA violation. There is no private right of action, however, against a physician for violating EMTALA. ...Private EMTALA actions are subject to a two-year statute of limitations."[2]

What if an on-call physician refuses or fails to show up or answer when called?

The physician's name and address will be included in the medical record and he or she may be subject to sanctions.

Glossary

Emergency medical condition: The statute defines an "emergency medical condition" as:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> > (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> >
> > (ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [*sic*] who is having contractions —

(i) there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or unborn child.

Medical Screening Exam (MSE): "The process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin) a screening process that is reasonably calculated to determine whether a medical emergency condition exists, it has met its obligations under [EMTALA]. Depending on the patient's presenting symptoms, the medical screening examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests and procedures."

Stabilization: "Under the statute, "to stabilize" an emergency medical condition means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman], to deliver (including the placenta)."

Transfer: "Movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by or affiliated or associated, directly or indirectly, with the hospital, *but does not include such a movement of an individual who:* (A) has been declared dead, or (B) leaves the facility without the permission of any such person." (AMA)

REFERENCES:

[1] New Outpatient Prospective Payment System regulations, expected to be implemented October 10, 2000, may change this guideline.

[2] Kamoie, Brian E., "EMTALA: Reaching Beyond the Emergency Room to Expand Hospital Liability," Journal of Health Law, Winter 2000.

THE CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance

The ***CMS Office Manager*** is a genuine Medical Office Resource.

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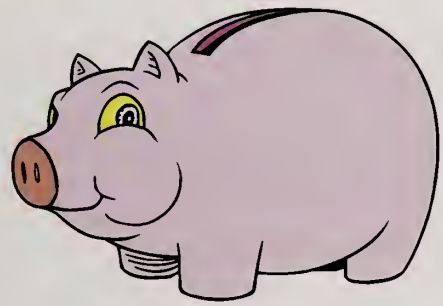
David C. Martz, MD
President, CPN

As we approach the annual CMS meeting (which will be history by publication), we are prompted to review CPN's experience over the past year. It is helpful to summarize the individual developments previously reported in this column.

We have seen significant growth in membership on the Front Range; we are now second only to Mesa County in RMHMO enrollment. We have been granted a seat on the RMHMO Board of Directors, and membership on its finance committee. A Front Range Utilization Management committee made up of CPN and RMHMO leadership has been meeting monthly. We have four new energetic members on the CPN Board. Financial losses have been substantially reduced by the "All Hands On Deck" initiative.

We have linked a significant increase in reimbursement with redefinition of the sense of partnership with our physicians in the Denver Metro and Colorado Springs regions. And, we are now embarking on an intensified program of communication and commitment with individual physicians as well as hospital administrators and employers in selected communities, so we may serve more effectively and efficiently.

Yes, it has been a very good year! Hopefully, the next one will be even better!!



Save This Day

What: Legislative Day
When: Monday January 29, 2001
Where: Colorado State Capital
Who: All physicians and spouses across the state are invited.

- 8:00-9:30 Complimentary Continental Breakfast (outside Old Supreme Court Chambers)
- 9:30-11:30 Informative sessions with selected Legislators.
- 12:00 Lunch with your legislator (at the Adams Mark Hotel Downtown Denver) ($23.00 per person)

Legislative Day is sponsored by the Colorado Medical Society Alliance in cooperation with the Colorado Medical Society. Please plan to come. This is an excellent opportunity to become acquainted with your legislators and pertinent health related legislation.



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Pierre Malek, MD, named new CFMC Medical Director

The Board of the Colorado Foundation for Medical Care is pleased to announce the selection of Pierre M. Malek, M.D. as Medical Director, effective September 26, 2000. Dr. Malek is succeeding Dr. Thomas R. Dunn, who announced his intention to retire from the Foundation earlier this year, after serving as medical director for the past 12 years.

Dr. Malek brings a comprehensive background that includes 20 years of clinical practice, academic appointments with the University of Texas Health Science Center, and an extensive knowledge of the complex healthcare issues facing society. Most recently, Dr. Malek served as Vice President and Senior Medical Director for the Medical Claims Management division of Aetna U.S. Healthcare/Prudential Healthcare. Prior to his employment with Aetna, he held several senior positions in the managed care field, including being a National Medical Director for United HealthCare, Medical Director for MetraHealth, FHP of Colorado and Take Care Colorado. Dr. Malek is a member of the Board of Directors of the Physicians Alliance for Medical Management Solutions. A resident of the Denver area, he has, since 1992, been affiliated with CFMC in a variety of collaborative and consulting capacities, including being an associate medical director and physician reviewer.

Dr. Malek is Board Certified in Internal Medicine, a Fellow in the American College of Physicians, a Certified Coding Specialist, and a Physician Consultant for the Colorado Personalized Education for Physicians (CPEP).

The 120 employees of CFMC work with the government's Medicare, Medicaid, and TRICARE programs, as well as health providers and payers, to collaboratively improve the quality of health care and assure appropriate utilization.

Rural Health Conference

The 10th Annual Colorado Rural Health Conference will be held in Limon, Colorado, June 19-21, 2001.

For information on the conference, contact the Colorado Rural Health Center at 225 E. 16th Avenue, Suite 1050, in Denver. To find out all about Limon, Colorado, go to ***www.ruralnet.net/limon.***

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Community Meetings Planned on Services Needed by Colorado Youth

A series of public meetings will be held throughout Colorado, beginning on Wednesday, October 11, to request assistance from prevention, intervention and treatment service providers and the general public in developing the first state plan for the newly created **Division of Prevention and Intervention Services for Children and Youth.**

The meetings will be held in Alamosa, Denver, Durango, Grand Junction, Greeley and Pueblo.

The new division, which was created by the Colorado Legislature during its 2000 session, is part of the Colorado Department of Public Health and Environment and has been given responsibility for delivering prevention and intervention services for the state's children and youth. Several programs from the Colorado Department of Local Affairs and the Colorado Children's Trust Fund were moved to the department in mid-July as part of the new division.

Cynthia Honssinger, the State Health Department's director of Legal and Regulatory Affairs and the acting director of the new division, explained that the state plan will be designed to coordinate and provide direction for delivering prevention, intervention and treatment programs operated by the division and by other state departments to ensure collaboration among existing programs throughout Colorado. "We consider community input to be crucial to developing a state plan," Honssinger said. "The meetings will help forge state and local prevention partnerships that foster the health and well-being of Colorado children and youth and will provide an opportunity to identify community needs in order to better streamline statewide youth programs and services," Honssinger added.

Schedule for the public meetings:

Durango: 1-4 p.m., Wednesday Oct. 11, La Plata County Building, Durango Council Chambers, 949 East 2nd Ave.

Grand Junction: 9 a.m. -12 p.m., Thursday. Oct. 12, Partner's Recreation Center, 248 Colorado Ave.

Pueblo: 1-4 p.m., Tuesday, Oct. 17, Pueblo Community College, Occiato Theater, 900 W. Orman Ave.

Alamosa: 9 a.m- 12 p.m., Wed., Oct. 18, Adams State College Library, First Floor, 1st St. (College Center)

Greeley: 1-4 p.m., Tuesday. Oct. 24, Union Colony Civic Center, Hensel Phelps Auditorium, 701 10th Ave.

Denver: 1-4 p.m., Tuesday. Oct. 31, Denver United Way Building, Founders Room, 2505 18th St.

For more information about the public meetings, call (303) 692-2028.

"Involving Youth in the Future of Rural Minority Health" is goal of Rural Health Association Conference

America's youth will be the focus of the National Rural Health Association's (NRHA's) 6th Annual Rural Minority Health Conference. Youth leadership programs, education and career preparation, and intergenerational connections will be addressed as well as health and behavioral issues such as violence, drugs and alcohol, family and child development, and injury prevention. The conference will be held Dec. 7-9, 2000, at the Hyatt Regency Hotel in Savannah, GA.

The 2000 conference is funded in part by the Office of Rural Health Policy, Health Resources and Services Administration (HRSA), and the Bureau of Primary Health Care, HRSA, with scholarships sponsored by the W. K. Kellogg Foundation.

Conference participants will gain awareness of the special health concerns of rural racial and ethnic minorities and underserved populations and learn how to mobilize community members to plan and prioritize and develop solutions.

Maria Guajardo Lucero, Ph.D., director of Assets for Colorado Youth with the Search Institute, will present the keynote session. She will discuss the need to work with youth, ideas to help increase youth involvement in rural communities, and ways to promote and enhance the health and well-being of rural minority youth. Also featured will be Alfred "Coach"

Powell, a nationally acclaimed youth motivational speaker, who will offer his perspective on how rural organizations, health providers and community can work together on issues that affect youth and rural minority populations. Also, panel discussions will pair adult professionals and youth representatives to discuss youth peer educator programs focusing on health issues such as HIV/AIDS, teen pregnancy and violence prevention.

A new aspect of this year's Rural Minority Health Conference is the ***Health Professions Showcase***, which will display models of youth leadership, career awareness and recruitment, and outreach programs. Presenters will have the opportunity to display and discuss their health professions programs with conference attendees. Additionally, a poster session during which authors will be on hand to discuss their work is scheduled.

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The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

". . .way behind the curve."

It's 6:00 AM and it's still dark outside. I turn on my office computer and go to the Internet to a "live" camera shot of Trafalgar Square in London, England. The sun is shining there; people are going at full tilt; traffic is heavy (as usual); sidewalks are full to overflowing with people, shoulder to shoulder, moving at a rapid pace.

It is now 6:02 AM in Denver and still dark. I look out my office window. A car goes by, made prominent only by its headlights. You have to assume there's someone in the car. Everything is quiet. When I arrived, nothing else moved; no one was around. It seemed as though I was the only person in the world. In less than three minutes I was watching the whole world go by. All those people I could see there in London had already been up and busy with the day's activities for seven hours or more: it's already 1:03 PM there.

Because of the Internet, I find myself forever trying to catch up to people across the world. I don't mean physically; I mean mentally. In my mind I find myself forever wondering what has happened to the ensuing seven hours.

This is typical of the frustrations which grow out of our new *"Computer/Internet"* culture. We are forever trying to catch up to some one or some thing. We are a culture of people that cannot stand to be "behind" any thing (this is extremely true of younger automobile drivers).

Back to the office at 6:02 AM: if you are communicating with someone in a different time zone via the Internet, communication becomes disorienting. Using England as an example: I have friends in London, and they are living seven hours ahead of me. When I write them from home of an evening, I'm thinking in terms of talking with them at 7:00 or 8:00 PM, but they are **already in bed**, asleep, waiting for the alarm to sound, starting a new day in a couple of hours. When I think of this while writing them, the fact immediately alters my communication. It's as if I am now talking to them while they are lying there in bed, asleep, having no idea that I exist. I feel as though I should apologize, so I say, "Well, I'll wait until tomorrow when they're up to talk to them." But it doesn't happen. Tomorrow, when they're sitting at their computer, ready to chat, you're just going to lunch with no thought of chatting with them. When you arrive home that evening and check your E-mail, you find that they wrote to you seven hours ago, and whatever they said is history: they're already in bed, sound asleep . . . **again**.

You see, I have this constant nagging that I'll never catch up, or that I'll never be on ordinary friendly terms with them because we can't talk on the same level.

It makes me think of the early days of the Pony Express mail service, where someone wrote a letter and that piece of paper was carried in a saddle bag on a horse, travelling hundreds of miles to reach another person. It often arrived a number of days or weeks after the message was written. Even with airplane, train and truck transport of the mail, I still marvel that some message on a piece of paper can find me here in my cubicle, days or even weeks later. When I receive such a message, I automatically tune my mind to the fact that this writer is at some distant place in a different time zone, possibly a different culture. I don't expect to communicate on immediate terms. Now, however, I'm frustrated because I can't seem to level out the playing field; I know I **have** the ability to communicate immediately but I **cannot** communicate immediately.

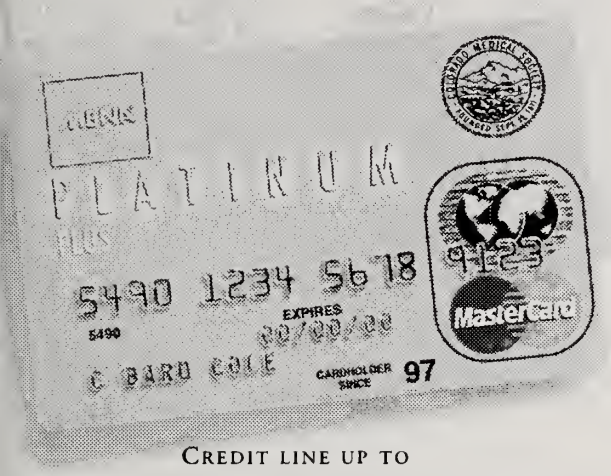
In the letter delivered by hand, we anticipate that the message will be historic. In a letter delivered electronically, we expect the communication to be immediate, and it is that expectation of immediacy that has me continually confused and frustrated.

I now understand the term, "time warp;" we must adjust our own psyche to deal with these daily differences, this cultural shock wave.

My Internet communication is continually frustrating for all this. I'm beginning to feel inferior and way behind the curve; I can never catch up! The only logical solution is to quit communicating with anyone outside of one time zone to either side of me. That way, we can be talking "immediately", or at least on the same day.

I liked it better when . . . . .

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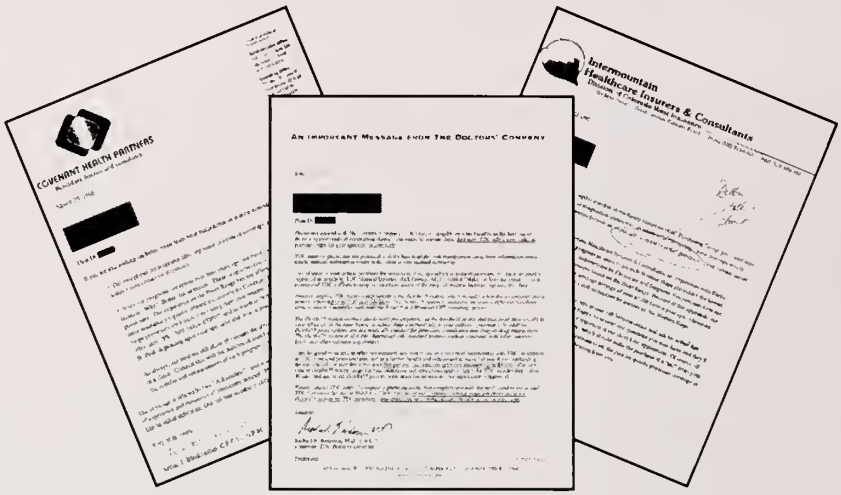
A Tribute:

Harold "Hal" Williamson, member of the Board of Directors, The Copic Companies

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The loss of a great friend and associate by Jerome M. Buckley, MD ..... **page 400**

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Cover Story

Harold Williamson was a quiet but efficient man, right to the last. He will be missed in the administration of The Copic Companies (See "Copic Comment" pg 400)

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO 80230-6902. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Denver, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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President's Letter



Richard Allen, MD
President 2000-2001
Colorado Medical Society

After all of the excitement and business which was transacted at the recently concluded annual meeting in Aspen, not only myself but all of the staff are busy trying to assimilate and act on the proceedings of the House of Delegates. One of my first actions was to make some new appointments to the Executive Committee. Because we are losing George Shanks, and I felt it was important to keep some continuity from the Western Slope, I replaced George with Paul Jones. I also felt we needed some representation from Clear Creek and therefore have also asked Lynn Parry to join us on the Executive Committee. We have just had our first meeting and will be meeting regularly every month. There will be plenty to report on at our first Board meeting, November 17th. Also, Louise McDonald and I have set up a regular schedule to meet weekly. I have started meeting with the various staff directors to discuss their responsibilities and committee assignments, and we are in the process of making appointments and reappointments. Our very capable Government Relations Director, Suzanne Hamilton, is still out on maternity leave and we are anxiously awaiting her return after the first of November as we will have a very full legislative agenda. I have asked Chris Unrein to remain as chair of the Legislative Council.

Over this past summer both Jack Berry and I attended regular meetings of a task force that was set up by the Division of Insurance to look at rural health and the small group insurance market. There have been major concerns by the various insurers over the high costs of insuring small groups and dealing with the problem of network adequacy. The DOI task force is broken up into various small groups who have been working with a facilitator to come up with possible solutions, and possible recommendations to the legislature. Their goal has been to provide affordable access to all Coloradoans. That's certainly a goal which we subscribe to and it is important that we are at the table to make sure they follow their mission statement. Our CMS/HMO Association Joint Committee has also been meeting regularly and has developed a subcommittee to look into forming a code of conduct on which all HMOs and physicians could come to agreement. Our own Managed Care Task Force has made a number of recommendations including trying to find a reasonable time to review new contracts and decide whether physicians would want to continue to participate with the various plans. Physicians did not wish to have their names marketed by the health plans unless they had agreed to participate with that plan. In any case, the subgroup of this task force is looking at ways to see if insurers and the physicians of CMS can find some common grounds of agreement where both sides could agree to behave ethically and responsibly. This is another work in progress which will continue for some time and I will keep you updated.

By the time this issue of Colorado Medicine is in your hands, the elections will be over, but as I write this there is still a great concern over a number of the ballot issues and the make up of the Colorado House and Senate. COMPAC has been busy representing you and naturally can benefit from your membership. COMPAC is bipartisan and looks for candidates to support who will be friendly towards medicine. In future issues we can look at some of the up and coming legislative items and I'm sure the Legislative Council will have their own views put forward.

I have received very positive feedback from those who attended the Annual Meeting regarding our theme of professionalism. For the past two years, now that there is no longer an interim House of Delegates, CMS has put on an educational forum looking at topics of interest for our members. Although this year's budget has no funds set aside for such a meeting, I feel it might be worth considering an educational conference looking at the various aspects and need for communication with our profession. Thus, we would look at not only communication between doctors and patients but between doctors and managed care entities much as we are addressing with the task force mentioned above. Again, I will give you more information as we develop this idea.

I would also like to emphasize that your communication with CMS is a two way street. Not only do I feel obligated to communicate with you and keep you informed of what is developing within our profession and within our state, but I certainly welcome your comments regarding issues with which you feel CMS can be of help to you. Let us know where we can help.

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Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Supreme Court Defines Jurisdiction of Committee on Anticompetitive Conduct

By *Amy Cook Olson, Associate*
Montgomery Little & McGrew, P.C.

Two recent decisions are of interest to physicians. In the first decision, the Colorado Supreme Court held that the Colorado Committee on Anticompetitive Conduct's jurisdiction over antitrust allegations is limited to those actions arising out of adverse decisions regarding physician competency, and does not include those actions arising from hospital business decisions. Second, the U.S. District Court struck down the Colorado Parental Notification Act, finding it unconstitutional.

Ryals v. St. Mary Corwin Regional Medical Center[1]

This case dealt with the question of whether a physician, who was denied hospital privileges, was required to file a claim against the hospital with the Colorado Committee on Anticompetitive Conduct before he could sue the hospital in court. The Supreme Court held that if the denial of privileges does not arise out of professional review committee activity at the hospital, then the physician need not seek review before the Committee on Anticompetitive Conduct.

Dr. Jarvis D. Ryals, a neurologist, had been a member of the medical staff at St. Mary-Corwin Regional Hospital (the Hospital) since 1976. Prior to 1995, the Hospital did not own an MRI scanner and Dr. Ryals interpreted MRI scans for the Hospital's patients outside of the Hospital at Southern Colorado MRI, Ltd. (SCMRI). Dr. Ryals, the Hospital and Pueblo Radiological Group were joint partners in SCMRI. SCMRI closed in December, 1995 and the Hospital subsequently obtained its own MRI for in-house use.

Dr. Ryals submitted an application for MRI privileges in February, 1996 to the Hospital's Medical Qualifications Committee. The Committee found that Dr. Ryals was qualified to read MRIs, but decided that the Hospital's exclusive contract with Pueblo Radiological Group prevented other doctors from reading MRIs. When Dr. Ryals requested that the Committee renegotiate the terms of their contract to allow other doctors to read MRIs, they declined. After his application was denied a second time, Dr. Ryals filed suit claiming that the Hospital had engaged in anticompetitive conduct. The trial court dismissed Dr. Ryals' suit, holding that Dr. Ryals was first required to exhaust his administrative remedies with the Committee on Anticompetitive Conduct. The appellate court affirmed and the case was appealed to the Colorado Supreme Court.

The Colorado Committee on Anticompetitive Conduct (CAC) was created in response to a 1988 U.S. Supreme Court decision in *Patrick v. Burget*

(continued on next page)

which held that a hospital's peer review committee was not immune from federal antitrust liability. [2] Because the peer review committee did not qualify for immunity in *Patrick*, it was determined that the individual committee members could be subject to suit for violating federal antitrust laws. In order to qualify for state action immunity, the Supreme Court held that a state must actively supervise private peer review committee activities. The CAC was created to provide the required supervision.

If a physician believes that a decision made by a peer review committee or a governing board stems from anticompetitive motivations, he may appeal the decision to the CAC. The CAC is a state board comprised of four licensed physicians and one attorney with expertise in antitrust. In order to appeal to the CAC, a physician must have been subject to a final action by a governing board resulting in denial, termination or restriction of privileges, membership or participation in an organization and must believe that the action resulted from anticompetitive conduct. The CAC is the sole and exclusive remedy for physicians believing their adverse peer review decisions are the result of anticompetitive motivations. If the CAC finds that the final action of the governing board resulted from anticompetitive conduct, they may issue an order disapproving, setting aside or modifying the final action. The CAC is not authorized to award money damages. Following the CAC's final determination, a physician may challenge the action of the governing board in district court.

The Colorado Medical Society filed an Amicus Curiae (friend of the court) brief advocating that the Supreme Court reverse the Court of Appeals' decision in *Ryals v. St. Mary Corwin Regional Medical Center*. The Society argued that the Court of Appeals' decision would interfere with the legislative goal of protecting the public from unqualified, incompetent and unprofessional medical care. In creating the CAC, the legislature sought to further this goal by fostering the effective peer review of physicians' professional qualifications, competence and conduct. By improperly expanding the scope of CAC's jurisdiction beyond supervision of peer review, the Court of Appeals altered CAC's role, which in turn threatened to dilute its effectiveness. The Society also argued that the Court of Appeals' decision would limit the access of all physicians to the courts by requiring exhaustion of administrative remedies in settings where the legislature intended none. The result of this unintended barrier would impede physicians' access to the courts.[3]

The Supreme Court agreed with the Society's argument and held that the legislature intended that CAC's jurisdiction over claims of anticompetitive conduct was limited to those arising out of professional review committee activity. This activity included assessing physician qualifications, physician conduct and quality and appropriateness of patient care.

In Dr. Ryals' case, the Hospital did not engage in any professional review committee activity in denying Dr. Ryals' MRI privileges. Rather, they made a business decision unrelated to Dr. Ryals' qualifications or conduct. Therefore, the court concluded, Dr. Ryals was not required to file his claims with the CAC before seeking a remedy in court.

This case was returned to the trial court for determination of the merits of Dr. Ryals' antitrust claim against the Hospital. The Society has taken no position on the merits of this claim.

Colorado Parental Notification Statute Unconstitutional[4]

On August 16, 2000, the U.S. District Court for the District of Colorado held that the Colorado Parental Notification Act, C.R.S. § 12-37.5-101 et seq., was unconstitutional. The Act generally prohibited physicians from performing abortions on minors until at least 48 hours after written notice was served on the minors' parents. Planned Parenthood filed suit claiming that the statute violated minors' rights under the U.S. Constitution. Governor Owens defended the statute with representatives of all Colorado District Attorneys Offices joining. The U.S. District Court agreed with Planned Parenthood, reasoning that the U.S. Supreme Court required that any abortion regulation except from its reach an abortion medically necessary for the preservation of the mother's health. Since the Act failed to provide this exception and the delay inherent in the Act's notification requirements would place some women at risk of injury or death, the Act was found unconstitutional. The Court accordingly enjoined the defendants from enforcing the Act. This case is currently on appeal with the U.S. Court of Appeals.

No stay of the U.S. District Court opinion was

(continued on next page)

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requested or granted pending the U.S. Court of Appeals' decision. Therefore, physicians are advised that the U.S. District Court's decision finding the Act unconstitutional stands and that law enforcement are enjoined from enforcing criminal provisions of the Colorado Parental Notification Act pending the outcome of the appeal. As the Act was explicitly found unconstitutional, it is unlikely that a civil action based on violations of the Act would withstand challenge.

[1] Colorado Supreme Court, No. 99SC137, September 18, 2000.
[2] *Patrick v. Burget*, 486 U.S. 94, 108 S.Ct. 1658 (1988).
[3] The CAC also filed an amicus brief asking that the Supreme Court recognize its limited jurisdiction.
[4] *Planned Parenthood v. Owens et al*, U.S. District Court, 107 F.Supp. 2d 1271, August 16, 2000.

Correction

A discerning reader has pointed out two errors in my September 2000 MedFax article, "Two New Supreme Court Abortion Cases." Both errors are in the second column of the second full paragraph. First, the D&E procedure was inadvertently referred to as meaning "dilation and extraction." It should have read, "dilation and evacuation." Second, the State of Nebraska argued that the D&X procedure could be constitutionally banned because it was unnecessary to preserve either the mother's life or health. The reference only to the mother's life was incorrect. I regret any confusion created by these errors.

Bob Spencer

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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Have you read your medical staff bylaws lately? If you are an employed physician, have you read your employment contract lately? Have you read your managed care contract(s) lately?

Based on the phone calls I have recently received medical staff bylaws are, in certain areas, becoming troublesome for physicians. Today more than ever, the medical staff organization must serve as a counterweight to market pressures for cost containment, and to the inappropriate lay interference in patient care. Through properly drafted medical staff bylaws, physicians are empowered and define the medical staff's relationship with the hospital and other health care entities.

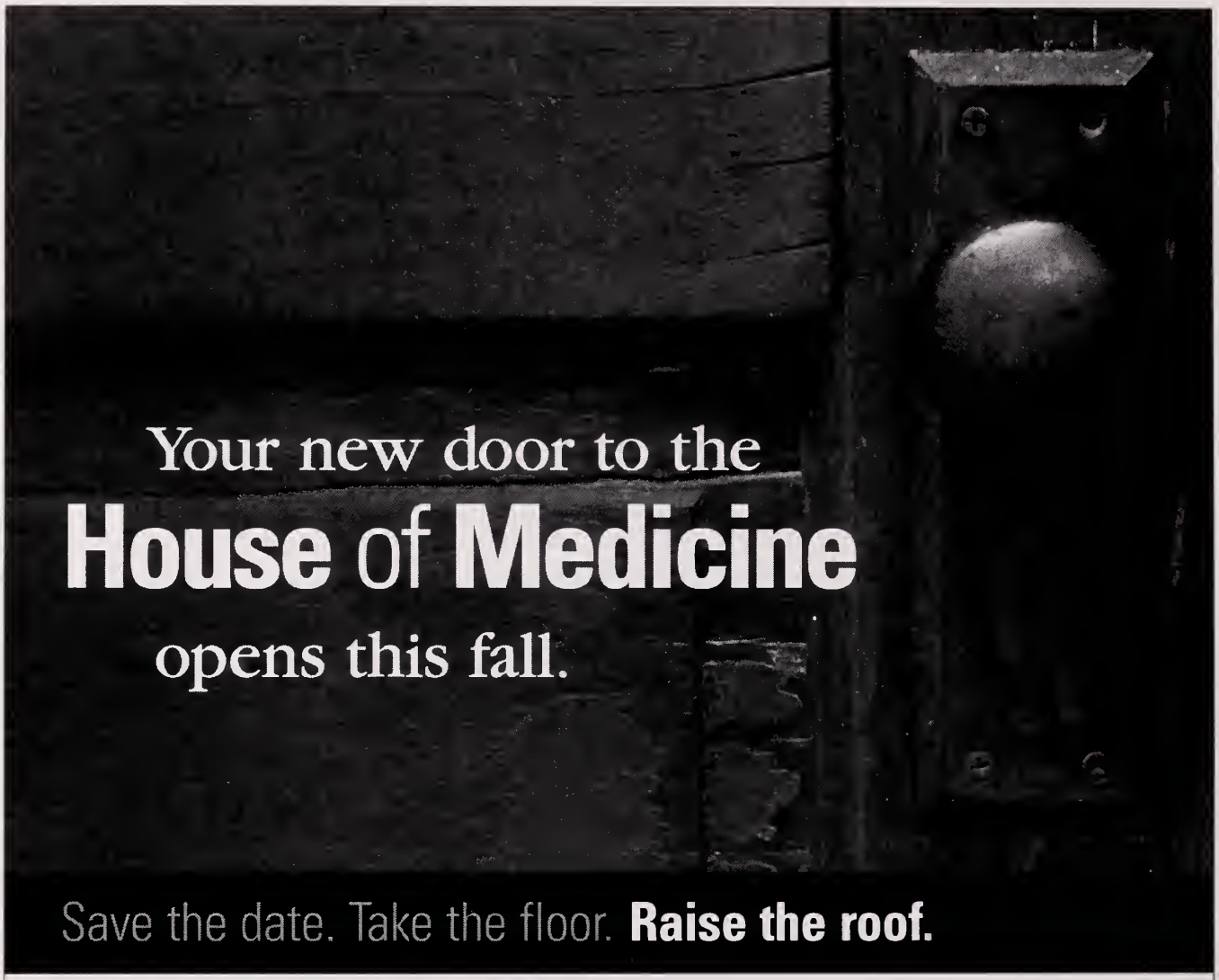
The first issue that arose was "Emergency Coverage Requirements". Typically, bylaws will state that except for honorary and retired staff, the responsibilities of each member of the medical staff shall include participating in such emergency coverage as may be determine by the medical staff. A situation was reported to CMS indicating that a physician specialty group had decided to not take emergency room call. The hospital revoked staff privileges for this group because of this decision. Furthermore, a health maintenance organization was notified, one which contracts with the hospital, that this particular specialty group no longer had staff privileges at the hospital. The language in the contract between the managed care company and the physician group states that participating physicians must maintain privileges at all hospitals with which the HMO contracts. Upon learning that the physicians no longer had privileges, the HMO terminated the contract with the physicians. It is imperative that you review both the medical staff bylaws and the HMO contracts you have signed to determine what requirements must be met. CMS sought legal counsel's advice on this matter. We learned that at the present time, there is not much that can be done. The contracts were already signed and bylaws were in effect. What I find very interesting is how the HMO contract was directly linked to the medical staff bylaws. The physician group has now lost a managed care contract in addition to facing the possible loss of staff privileges at a large metropolitan hospital. Perhaps there is a way to tackle this issue on the legislative level. CMS will continue to research the issue and provide you with further information as it is gathered.

The second issue centers on physicians who are direct employees of the hospital. Physicians in a rural community were told that since they were direct employees of the hospital, the peer review process as stated in the medical staff bylaws, did not apply to them. There are two separate and distinct issues here. One is direct employment and the other is peer review. One is not tied to the other. The medical staff bylaws must identify an appropriate peer review process. Any physician who has staff privileges at a hospital is entitled to these processes. In fact, the Colorado Revised Statutes contain specific language addressing peer review processes in hospitals. It does not matter if the physician is a direct employee of the hospital. The physician's employment contract is just that, an employment contract. It must not contain language that prohibits a physician from being afforded appropriate peer review. In addition, bylaws should not contain language that prohibits employed physicians from being afforded appropriate peer review. If you are a physician employed by a hospital, it would very wise to review your employment contract as well as your medical staff bylaws. CMS remains in contact with legal counsel on this matter as well.

"Bottom Line: review and research your medical staff bylaws, managed care contracts, and employment contracts."

Bottom-line: review and research your medical staff bylaws, managed care contracts, and employment contracts. The goal of this review is not to eliminate such contracts but to improve the ability of physicians to provide high quality care to their patients, without outside interference.

If you have any examples of problems in either one of these areas, please do not hesitate to contact me. I really need your input.



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Welcome to CMS!



Emily Larson, MSM

Ms. Emily Larson, MSM, is the newest member of the CMS staff. Ms. Larson came to CMS the first week of September, 2000, as an Administrative Assistant with the Colorado Medical Society Foundation. Her responsibilities are in support for and organization of the Colorado Coalition for the Medically Underserved and the CMSF.

Ms. Larson was born (on Groundhog Day) in 1975 in Berthoud, Colorado. She attended the University of Colorado at Boulder where she earned a Bachelor's Degree in Kinesiology. Following school she worked as a Physical Therapist Aid at NovaCare Physical Therapy. She received a Master of Science in Management from the University of Denver in 2000, her major being Health Care Systems Management.

Emily enjoys camping, hiking, skiing, travel, and photography. While at the University of Colorado in her undergraduate days, she studied one semester with *"Semester at Sea"*, a three and a half month cruise/study program aboard ship, traveling around the world from the Bahamas to the west coast of the U. S.

Ms. Larson is a welcome addition to the CMS staff, bringing with her a bright personality and welcome sense of humor. She can be reached at the CMS Foundation, (720) 858-6333, or 800-654-5653, ext. 6333. Her e-mail address is *Emily_Larson@cms.org*.

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Thank You

by Bill Pierson
Managing Editor

Thanks, Bob!



Robert B. Sawyer, MD

After only 42 years of practice, "Dr. Bob" has tossed in the scrubs for the last time (he says).

Robert B. Sawyer, MD, has retired. During most of his years in practice, Bob Sawyer was also at the center of the action in organized medicine. He has been one of Colorado's strongest physician advocates, but an unpretentious good friend.

In 1978-79, Dr. Sawyer served as President of CMS. Prior to that he was active in the formation of the CMS Professional Liability Insurance Company which became Copic Insurance. Sawyer developed a rather high-profile in the medical news after he wrote an op-ed piece for a national publication, entitled ***"One eye on the patient, the other on the courtroom."*** (AM News 6/6/77) Dr. Sawyer also served as Chairman of the Board of the Colorado Foundation for Medical Care, leading a campaign of driving down health care costs. He was an alternate delegate for 4 years and a delegate for 5 years to the AMA. He served as a Denver Medical Society delegate to the CMS House of Delegates from 1987 until this year.

Bob has been a member of the CMS COMPAC Committee since 1982 and served as chair for more than 10 years. He has served as chair of the CROP Resources Development Committee since 1997.

Bob Sawyer graduated from the University of Colorado at Boulder, in 1951, went on to earn his MD from the CU School of Medicine, did an internship and residency at Presbyterian Hospital in Denver, and has been there ever since. He served as President of Presbyterian Hospital. Dr. Charles Brantigan, a former partner of Sawyer's, said Bob has served on every board of the hospital in its development, redevelopment, sale, purchase and reorganization for the past 20 years. And still, he had time for a medical practice in surgery and sometimes family medicine. (Dr. Sawyer joined his father, Kenneth C. Sawyer, Sr., in practice and "inherited" many of his father's patients).

Bob Sawyer has always been a strong proponent for physicians taking an active role in community affairs. He has served on many such boards of directors and advisory panels. He was an active member of the Executive Board of the Denver Area Council of the Boy Scouts of America. He is currently chairman of the 9Health Fair Board; he has just completed 20 years as a member of the committee of the Denver Rotary Club's "Artists of America", which has brought outstanding American art and artists to Denver each year in this popular exhibition series. He also was a member of the Board of Directors of the Denver Rotary Club.

Bob served for 7 years as a CMS representative on the Colorado Code of Cooperation Committee. This is a CMS-created group made up of physician, hospital and news media representatives advocating more complete and effective dissemination of medical and health care news. He also chaired both the Denver and Colorado Medical Society Communications Committees between 1979 and 1987. In 1974 and 1976, he was a candidate for the University of Colorado Board of Regents.

Bob also found time to do two years with the U. S. Army at Brooke Army Medical Center at Ft. Sam Houston, Texas, 1962-1964.

And, oh yes, long ago he served as vice-president of the Hoolaulea Dance Club.

In recent years, Bob has slowed his practice to three days a week. He and his wife, Curly, have both given still more time to activities of the Colorado Medical Society. Bob has served on the Board of the Colorado Medical Society Foundation, and has remained active on the COMPAC Committee. Meantime, Curly Sawyer has been an active member of the CMS Alliance for the past 7 years, participating in many of the Alliance activities.

Bob and Curly Sawyer hope their "retirement" activities will allow them time for more travel and leisure. However, Bob's idea of retirement may interfere with those plans. Thanks, Bob!



John Farrington, M.D., President, CMSEF
Sopheap Na, Scholarship Recipient

Education Foundation

I would like to introduce the CMS membership to Sopheap Na, one of the recipients of our CMS Education Foundation scholarships. The following are some of her thoughts.

"To cure sometimes, to relieve often, to comfort always." Anonymous

A year has quickly passed since my first day at the University of Colorado School of Medicine. The third floor lecture hall established itself as a second home with countless hours at my favorite seat. Navigation of the various hallways, departments, and offices of the medical school became an effortless task. I began with the understanding that medical school would be a difficult path, but I was not prepared for the changes it brought to my life. A professional and emotional transformation overcame me – solidifying my vision of becoming a physician.

Academically, I was confronted with a spectrum of highs and lows. My undergraduate academic achievements became distant memories. I was surrounded by individuals who had also excelled in their individual paths. As expected, it was difficult to accept or even acknowledge that I was not performing at the high level as experienced during my undergraduate studies. The rigorous academic demands exceeded my initial expectations. Numerous times, it did feel like I was drinking from a fire hydrant. Frustration was an emotion that I quickly learned how to manage. The acceptance of the fact that it was okay to do poorly on numerous exams and not to know everything allowed me to appreciate the vast knowledge and company of my peers. I am amazed and comforted by the diverse backgrounds of my peers, which has brought growth into my life. Our similar goal has brought us together while our unique personalities and lives will enrich the medical profession and allow us to cultivate lifelong professional and personal friendships.

Emotionally, finding balance in my life was the biggest obstacle. During my first quarter, I easily allowed myself to become consumed with academic issues. It was during a late study session in the anatomy lab when I realized I was losing touch with myself. I had expected the rest of my life to be frozen in time while I focused on learning the intricate aspects of the human body. It transformed me into an unhappy individual, constantly questioning my motive for pursing a medical career. I realized that although my academic life was my focus, it was just as important for me to remain an active member of my non-academic life. My parents will not stop growing older. My siblings will not stop experiencing the process of growing up. My friends will not remain static in their life. There are always notes to review, another exam to study for, and a lecture to listen to. But it is essential to complement my personal life with my academic life. This allowed me to refocus my commitment to the medical profession.

In conclusion, my first year of medical school provided me with invaluable insights. I am one of the fortunate few to have the opportunity to experience a profession that is unlike any other. My course-work is the knowledge that will enrich my mind and form the foundation of my professional career. My preceptor is my mentor and role model of what it means to be a caring physician. My patients are my special, unique teachers by whom I am learning the important concepts of listening, understanding, and compassion. I am excited for what the future years of medical school and medicine will bring into my life. I expect to encounter many more obstacles and experience many more emotions. Adversities will only mold me into the strong and professional physician that I envision.

I would like to express a sincere and grateful thank you to the Colorado Medical Society for your financial support in the growth and development of my medical career.

Sopheap Na MSII
1999 CMS Scholarship Recipient



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Trends in Behavioral Risks
and Outcomes for Cardiovascular Disease, Colorado, 1990-1998

Elizabeth Lyon Hannah, Russ Rickard, Richard E. Hoffman, (Colorado Department of Public Health and Environment), and Ron Moolenaar (Centers for Disease Control and Prevention)

Cardiovascular diseases are the number one cause of death for all ages in the United States, resulting in over 960,000 deaths annually, and the number one cause of death in persons between 35 and 64 years of age, resulting in over 160,000 deaths each year.[2] In Colorado in 1996, cardiovascular diseases were the most common cause of death, accounting for 36% of all deaths.[3] In addition to high mortality, cardiovascular diseases are a significant cause of morbidity. The Centers for Disease Control and Prevention (CDC) estimate that over 58 million Americans, some 20% of the population, live with some form of CVD and over six million persons are hospitalized annually.[1] Stroke, which is the leading cause of disability in the US, affects over 4 million persons nationwide.[2]

Many contributing causes of cardiovascular disease have been identified which can be personally influenced, such as obesity, smoking, high fat diets, and untreated or uncontrolled underlying medical conditions.[4,5] Recent published reports indicate that physicians have a profound impact on patient dietary habits and exercise patterns.[6] In an analysis of Behavioral Risk Factor Surveillance System data from seven states and Puerto Rico, it was found that regardless of prior patient health risk, persons who received physician dietary and/or exercise advice were significantly more likely to engage in risk reduction activities.

Because of the prevalence and severity of cardiovascular disease, an analysis was undertaken to describe trends in the three main behavioral risk factors for CVD in Colorado (smoking, sedentary lifestyle, and overweight/obesity) and to compare trends in these behavioral risk factors with hospitalization and deaths from acute myocardial infarction (AMI) and stroke.

The Behavioral Risk Factor Surveillance System (BRFSS) was started in Colorado in 1990. The BRFSS is a telephone survey of a sample of the adult, non-institutionalized population. We used data from years 1990 through 1998 to calculate self-reported prevalence estimates for smoking, sedentary lifestyle, and overweight and obesity. A smoker was defined as a person who has smoked at least 100 cigarettes in their life and currently smokes. Sedentary lifestyle was defined exercising <20 minutes per day three days per week. Overweight and obesity were calculated using the body mass index: defined as weight in kilograms divided by the square of height in meters. Overweight was defined as a body mass index 27.3 for women and 27.8 for men. Obese was defined as a body mass index 30 for both men and women.

Hospital discharges were obtained from the Colorado Hospital Association Discharge data set. We included hospital discharges for AMI (ICD-9 code=410) and stroke (ICD-9 code=436) from 1990 through 1998. We excluded admissions from non-Colorado residents and persons <18 years of age. Data were unduplicated by year for each diagnosis code. Deaths due to AMI or stroke were ascertained from Colorado vital statistics records. Annualized Colorado population estimates were used to calculate rates per 100,000 population. Figure 1 displays the annual prevalence estimates for smoking, sedentary lifestyle and overweight for the population studied. The prevalence of sedentary behavior increased from 44.5% to 50.9% across the study period ($p<0.04$), and the prevalence of persons being overweight increased significantly from 16.5% to 27.2% ($p<0.002$). In general, smoking remained stable across the nine year study period. However, the youngest age groups had increasing smoking rates, with an increase from 23.4% to 26.6% ($p<0.05$) among 18-35 year olds. Smoking prevalence decreased or remained constant for all other age groups.

There were statistically significant increases ($p<0.01$) in AMI hospitalizations, unduplicated by year, during the study period for all ages ($p<0.01$) and among persons ≥55 years ($p<0.02$). In contrast, AMI death rates decreased significantly over the study period ($p <0.0004$). These contrasting trends may be due to improved care for AMI patients. Stroke hospitalization rates and stroke death rates both remained stable across the study period.

This study has several limitations. First, it is an ecologic study. The same people are not included in both BRFSS and hospital discharge/death certificate datasets, although these datasets provide consistent annual estimates of the adult Colorado residents. Second, BRFSS data is self-reported and may contain biases. Estimates from the

Trends in Behavioral Risks *(Continued)*

national surveys data indicate that due to under-estimation of weight and over-estimation of height, up to 33% more people may be overweight and obese. Third, hospital discharge data and death certificate data may be affected by coding practices of individual hospitals or physicians. Lastly, rates of AMI and stroke may be influenced by temporal factors, such as the introduction of new therapies.

In summary, during the 1990s Colorado residents ≥18 years have become significantly more overweight, obese, and sedentary. Smoking rates for Colorado residents did not decrease over the study period and are increasing in the youngest age groups. Hospitalizations for AMI have increased significantly, although death rates for AMI have decreased significantly. Stroke death rates and hospitalization rates have remained stable.

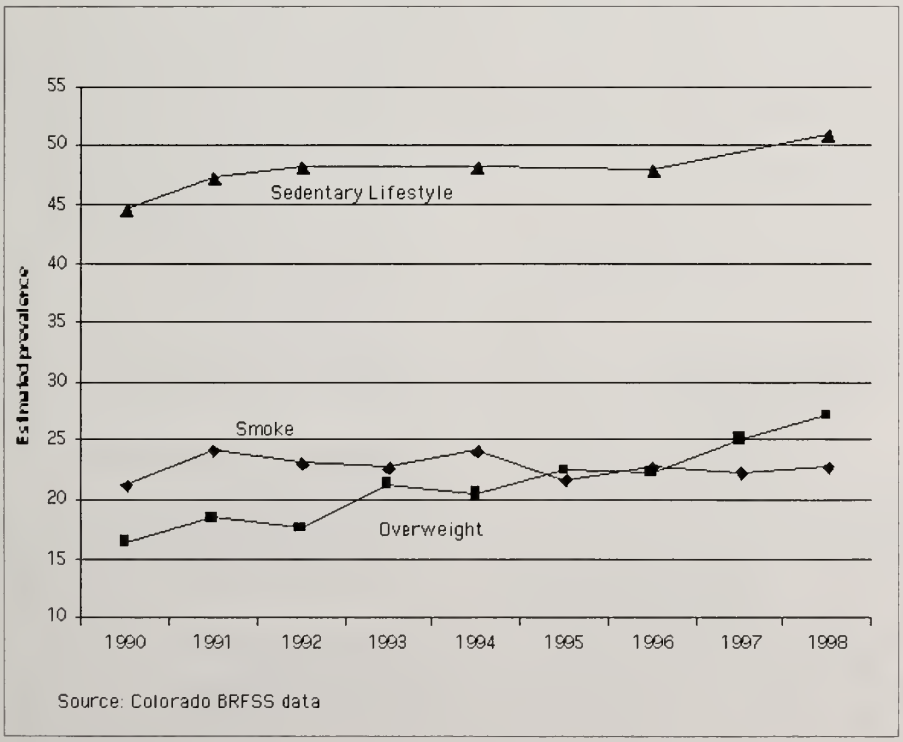
Colorado is generally healthy. We rank 48th out of 51 states and territories in percent of the population who are overweight, 44th in percent of the population who are sedentary, and 27th in percent of the adult population that smokes. Despite the limitations of the study and the preceding statistics, it is clear that physicians and other health care providers should continue to counsel patients on the dangers of smoking, being overweight and being sedentary. At the public health level, Colorado must implement prevention programs to (1) inform the public of the dangers of obesity stemming from poor diet, (2) promote exercise programs as a way to combat sedentary lifestyles, and (3) support smoking cessation and smoking prevention programs. Such efforts are now underway with tobacco settlement funds and new grants from the CDC.

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Figure 1 : Estimated prevalence of persons who smoke, have a sedentary lifestyle, or are overweight, by year, Colorado, 1990B1998 (sedentary lifestyle p<0.04, overweight, p<0.002).

Figure 1





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by Rich G. Kessel, Ph.D. & Erich G. Kirshner, M.S.

Vaccine Delay Promises to Make this Flu Season Challenging

This year's influenza season presents new challenges for Colorado physicians. Problems producing this year's influenza vaccine, combined with regulatory hurdles faced by vaccine producers, have combined to create a delay in the delivery of influenza vaccine. What that means for Colorado physicians is that they may be giving their patients flu shots after flu has already arrived in Colorado. This will make patient education especially important. Complaints that the flu shot caused patients to get the flu are, almost certainly, going to arise since a few patients will become infected by the virus before the influenza shot is able to provide them with sufficient resistance – usually two weeks after administration. Patients should be reminded that the influenza shot contains inactivated virus strains and there is no risk that the shot will cause the flu.

Besides presenting unique challenges for providers, the delay in vaccine delivery has also created many challenges for the Centers for Disease Control and Prevention (CDC) and other agencies charged with ensuring the nation's high risk individuals get their influenza shot. While every year the CDC urges providers to get their patients at highest risk immunized against flu, this year the agency has strengthened its message. The agency has asked that those at high risk be given priority in November, while low risk individuals can receive their shots in December. Persons at high risk of death from influenza-related illness include persons 65 and older, persons with chronic diseases like diabetes and persons with heart, lung or kidney disease. Pregnant women and health care providers are also typically included in the flu priority category, since their health directly impacts the health of others.

The CDC notes that flu shots in December, and even later, can be effective in combating flu in Colorado. Some patients may question why shots were previously given in October and whether getting a shot later is equally effective. According to the Colorado Department of Public Health and Environment, some early cases of flu do occur in November. However, flu does not typically peak until after Christmas and some years the peak does not occur until after Valentine's Day.

While the CDC has predicted that there would only be a delay in vaccine delivery, not a shortage, physicians may find it difficult to buy vaccine. If you do not have access to vaccine, you can send your patients to public clinics conducted by providers such as the Volunteer Nurses Association. For a list of clinic times and locations, visit the Channel 9 News Internet web site at ***www.9news.com .***

Finally, any discussion of influenza vaccinations would not be complete without a mention of the importance of pneumococcal vaccination for persons 65 and older. Unlike influenza vaccinations, the pneumonia shot does not have to be administered each year.

For more information on influenza and pneumococcal vaccinations, contact Will Schluter, MD, CFMC Health Care Quality Improvement Program Director, at (303)695-3300, ext. 3019.





W. Gerald Rainer, MD
Historian
Colorado Medical Soiety

In assuming the job of Historian for CMS, I found I had about 129 years of catching up to do before I could dive into the job. As a result, when a request was referred to me about some early Weld County physicians, I was pleased to run across an extremely interesting chapter in Colorado's medical history.

What piqued my curiosity was the reference to *Ella Avery Mead, MD, Greeley, Colorado.*

Dr. Mead was one of two female physicians in Greeley near the turn of the **last** century. The other was Dr. Florence Fezer. Dr. Mead's parents were Weld County pioneers. Daughter Ella was born in Monrovia, New York, and she was only four in 1878 when her parents took a train west to the semi-cooperative town championed by the editor of the *New York Tribune* and named for him. On her way west she contracted whooping cough, generously spreading the illness with fellow passengers and Greeley colonists. This, she later said, contributed to her interest in public health.

In the Greeley colony of 1905, when she set up practice, delivery of babies on the kitchen table was not uncommon. Dr. Mead introduced the idea of hospitalization for childbirth by delivering her sister's son in the Weld County Hospital. He was the first "hospital baby" in the county. Dr. Mead served for many years as a public health official. She attended the University of Colorado Medical School, receiving her M.D. in 1903 and interned at Women's and Children's Hospital in Denver and Denver General. After her internship she returned to Greeley in 1905 to the new office of City Health Officer. She crusaded for programs for the handicapped and crippled and had established child guidance and mental hygiene clinics in the early 1920s. Dr. Mead was especially well known since she had the first car in the county with electric lights. It was a Maxwell.



Dr. Ella A. Mead, pioneer doctor of Greeley, as she appeared in 1906 in her new-fangled two-cylinder Maxwell. Headlights were said to be electric, but these look to be carbon lamps.

She helped establish a nursing service in the county during World War I. This service was continued after the war and was a forerunner of the public health nurse service and the county health department. She served as the registrar of vital statistics for the city and county.

In the late 1920s, Dr. Mead gained county support for a birth control clinic and carried on a private practice. In 1947, Dr. Mead was honored by the Colorado Medical Society for outstanding service in the profession and public health. Dr. Mead died in 1961. Weld County Hospital named its nursing home for Dr. Mead. She was honored in 1947 by CMS along with Dr. Florence Sabin. Both were recognized as pioneers in Colorado health. Both had an undying interest in public health, for which Coloradans can always be thankful. Because of these two women medical pioneers, Colorado has had an extremely successful public health department at both the state and the county levels.

Dr. Mead was the first woman applicant for enlistment in the U. S. Army in World War I. The application was refused for no women could then serve. *(Continued)*

The "other" Weld County female physician, Florence Fezer, was born on March 29, 1883, in Greeley. Dr. Fezer's father was the first pharmacist in the Greeley colony. When Florence graduated from Greeley High in 1901, the Class Prophecy stated: *"Florence Fezer has decided on the profession of medicine as her goal, which is equivalent to saying that she will accomplish her chosen work."* She certainly did "her thing" by becoming an eminent physician.



Dr. Florence Fezer upon graduation from the University of Colorado School of Medicine.

She was graduated from Colorado College in Colorado Springs and the University of Colorado School of Medicine. She acted as the medical examiner for the women's physical education department at Colorado State College of Education in Greeley (now University of Northern Colorado) and Colorado A&M in Fort Collins (now Colorado State University). She also maintained a private practice in both Greeley and Fort Collins. Dr. Fezer was an anesthesiologist by specialty. She began her practice in about 1913 and continued until her death in 1957.

Membership records in the CMS Archives show that she joined the Colorado State Medical Society and the Weld County Medical Society in 1916. Weld County Medical Society bestowed an Honorary Membership on Dr. Fezer in 1947. She became an Emeritus member in 1950.



Archer C. Sudan of Kremmling, Colorado, President of the Colorado Medical Society in 1946-47, presents the CMS Certificate of Service to two outstanding women physicians. They are (c) Dr. Ella A. Mead of Greeley, and Dr. Florence Sabin of Denver. Both were noted in their pursuits of better public health. Both were pioneers of medicine in Colorado. Dr. Mead held sway in public health matters in Weld County for many years, influencing many of the decisions made at the state level. Dr. Sabin made headlines and was noted nationally for her work in public health.



Dr. Fezer, from a newspaper photograph taken shortly after starting her practice of medicine.

Note: Much of the information in this article was taken from material prepared by Mrs. Melinda Thompson of the Weld County Medical Society Auxiliary in 1971. It was enlarged by Florence Clark and her staff at the Greeley Museum, and again by Ms. Hazel Johnson of the Greeley Tribune in 1977.

The theme of the Colorado Medical Society Alliance Annual Meeting at Aspen in September was, you guessed it, "Celebrating the '50s". Joyce Wilson, CMSA President, announced that the1950s came to bear because the meeting marked the 50 years of the AMA Foundation. The CMS Alliance has worked hand in hand with the AMA Foundation in many programs and efforts, including fund-raising for medical education and research. Colorado's Alliance has always earned high marks in its ERF fund-raising. This year, the Alliance members sold tickets for a raffle, which included giving away seven beautiful baskets of fruits, cheeses, candy and beverages. The raffle raised a record amount, $1,655.00.



The "Poodle" costume of the 1950s was the rage at the St. Regis Hotel in Aspen September 21st when the CMS Alliance Annual Meeting honored the 50th anniversary of the AMA ERF Foundation. In costume for the occasion were Alliance members (top row-standing l-r) Sarah LaMotte, Kim Moore, Don Gutentag, Winnie Kortz and AMA's Barbara Jett (guest speaker).

Seated (l to r) are Patti Brown, Nancy Kandel, Joyce Wilson, Linda Culberson and Gay Walker.

Guest speaker for the meeting was Barbara Jett, an AMA Alliance Field Director. Barbara spoke to the group about the 50 year history of the AMA Foundation. Her presentation involved the audience completely when Barbara used titles of 1950s hit songs to highlight her account.

As to the 1950s costumes, highlighting the "Poodle" look, many of the costumes were made by the participants. Barbara Jett, for instance, wore a light blue jacket which was decorated with likeness of 45 rpm records, the popular 1950s jukebox and more. Gay Walker wore a costume which included a green and gold high school letter jacket, a green poodle skirt and - what else -saddle shoes. Dr. Allan Kortz attended the dinner with his wife, Winnie, and they wore matching high school letter sweaters.

Don Gutentag, one of the few male Alliance members, wore the suit his father wore at his 1950s wedding. But there was more. The menu for the dinner meeting was "totally '50s", right down to the ***Tab***® soft drink.

It was a lot of fun and very colorful.

Tab® is a registered trademark of the *Coca Cola* Corporation

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Harold "Hal" Williamson - The Consummate Copic Board Member



I am in Buenos Aires, Argentina, writing this article. I will soon be on my way to Brazil to visit a dear friend I have not seen for 24 years; he's flying 1,000 miles from northern Brazil to meet me in Rio. Two nights before I left on vacation, I was visiting my friend and fellow Board Member Harold Williamson and told him of my plans. Hal told me how beautiful that was and how precious friends are. I asked him to be sure to be there when I got back, but Harold again shared his frequent wisdom and reminded me it was up to neither him nor me. Our plane was late getting to Miami. Minutes before I boarded the plane for Buenos Aires, I again called Harold's house and his brother Harvey told me Harold had gone into a coma earlier in the day. As a physician, I had truly misjudged the speed of Harold's demise. Again Harold's words echoed, "God is in charge." Harold's other words also echoed - "how precious friendships are." Harold "Hal" Williamson, CPA, the first non-management, non- physician Board Member of Copic went home on October 1, 2000 to his God, but in true auditing style he properly closed the third quarter first.

Hal became a member of the Copic Board in 1988. His task as he saw it was to bring "an outsider's" view - a non-insurance business perspective, a challenge to our thinking, an opportunity seeking dimension. Believe me, Hal did all that and more. His process was one of gentle respect, yet probing and profound questioning. He not only challenged us about the "what" Copic was considering doing, but more importantly made us defend both the "why" and the "why not."

Raised in Fort Collins, Hal received his Bachelor of Science in Business Administration from the University of Denver. He received the highest score in the state when he took the exam in 1954 to become a Certified Public Accountant (CPA). Hal joined the Denver office of KPMG Peat Marwick in 1954 and spent a career of 30 years with them. He was the youngest partner in the history of Peat Marwick's U.S. operations when he was admitted to partnership in 1963. Hal's career spanned a variety of audit, tax, and consulting services. The clients he served were principally in oil and gas, real estate, banking, or manufacturing. He also served clients with entrepreneurial start-up businesses. Hal retired from KPMG Peat Marwick in 1985.

When a lump under his arm was diagnosed as chemo- and radiation-resistant non-Hodgkin's lymphoma, Hal saw his task as incomplete and set out to accomplish his two remaining goals. First was that his non-physician Board member legacy must be continued. As the medical delivery system was dramatically changing, Hal knew Copic was in great need of non-physicians on the Board. In his humble manner he told me if I thought what he had contributed was of value, then Copic should consider replacing him with another non-physician. The Board not only saw Hal's value, but also complimented his insight by adding (not replacing - Hal will never be replaced) two other non-physician Board Members this past year. How fortunate Copic was to have had Harold "mentor" them these past nine months.

With that task behind him and God sending out a summons, Harold had one more task to accomplish.



The flag in front of Copic Companies headquarters was flown at half-staff in honor of Harold E. Williamson, a long-time Copic Board member who passed away on October 1.

Again, continuing his profound insightful "out-of-the-box" thinking, he was in full gear. He wanted Copic, especially The Copic Trust, to take a step back and look at Copic's core purpose - to allow the health care community to devote the greatest proportion of its resources to patient care. Hal needed the Board and Management Team to "hear him out!" Sick as he was (on round-the-clock narcotic pain medication just to be comfortable and requiring 24-hour oxygen due to metastases of the lymphoma to his lungs), Hal still found the strength and will, with unbelievable assistance from his ever-dedicated wife Kaye, to trek up to Vail (8,500 feet) and fully participate in Copic's 2001 Planning Meeting two weeks before his death. At that meeting, he presented to all of us the crescendo of the breadth and depth of his thinking. He implored us to know the total value of Copic's worth and then he cautioned us to take full responsibility to continually protect that value. It was quite a presentation. (Thank God, we have it on tape.)

Before he started his presentation Hal first thanked Copic for being so kind and supportive. However, Copic, the physicians of Colorado, and the field of medicine are the ones who must be thankful to Harold Williamson, the consummate Board Member. With his final two tasks completed, Hal came down his beloved hills for the last time.

With Hal's passing, the Copic family and the physicians of Colorado extend their heartfelt condolences to his loving and ever-supporting wife Kaye, to Harold and Kaye's combined family, and to Hal's twin brother Harvey. Your loved one and our dear friend has truly gone home to be with his God. We all will miss him dearly but likewise send a warning: with all due respect and gentleness Harold will want to know if you, God, have ever looked at it this other way.

Colorado Coalition for the Medically Underserved (CCMU) to implement a specialty referral network

Colorado's strong economy and record-low unemployment hide a disturbing picture - approximately 580,000 Coloradans have no health insurance or endure significant gaps in coverage. The majority of the uninsured are hard working people who find themselves trapped by circumstance, who hold jobs with companies that no longer offer health insurance for them or their family. More than 80% of uninsured adults work full-time or are married to someone with a full-time job. Even when insurance is offered, it is often at a rate that many individuals and families are unable to afford. They must choose between housing, food, clothing for their children, or health insurance. When these are the choices, health insurance is a luxury - a luxury that is just out of reach.

Compounding the problem is the fact that access to specialty and hospital care for these uninsured patients has decreased dramatically in Colorado. For this reason, the Colorado Community Health Network (CCHN) joined forces in the fall of 1998 with the Colorado Coalition for the Medically Underserved (CCMU) to implement a specialty referral network for uninsured patients.

The CCMU Referral Network is an organized system of Colorado hospitals and specialists who are willing to share their time and skills to serve the medically underserved. The goals of the CCMU Referral Network are:

- To create and coordinate a volunteer referral network of specialty providers and hospitals to meet the health care needs of Colorado's medically underserved populations,
- To increase access to affordable specialty care, and
- To improve health outcomes in Colorado.

Already, more than 70 specialty physicians participate in the referral network. As of August 2000, 350 uninsured patients were referred to specialists by the referral network, and 16 surgeries have been performed in 6 different metro area hospitals.

A patient who recently received surgery from a participating orthopedist had lost her job and was close to losing her home because of her injury. In a thank you note to the Referral Network she said: "This surgery has given me back my life...I hope I can help others the way you helped me!" The surgery made it possible for her to keep her home and find new employment. While the majority of cases are not this dramatic, many more patients need specialty consults that are currently unattainable through any other mechanism.

As the number of uninsured Coloradans continues to rise and resources of traditional safety-net providers are stretched to the limit, more specialists are needed to meet the health care needs of uninsured Coloradans. Currently, CCMU Referral Network patients must wait 1 to 4 months for a specialty referral and some cannot be referred at all because many specialties are not yet participating in the network.

We believe the first step is to ask physicians to help in some small way. More specialty physicians are needed to provide specialty consultations in their office to Community Health Center patients on a sliding fee scale. Some participating specialists have agreed to see patients one time per week, others one to two times per month. Every consult is one step further to meeting the needs of Colorado's medically underserved. Please take the time to contact Anna Barrett at the Colorado Community Health Network (CCHN) (303) 861-5165 x232 or email anna@cchn.org if you would like to participate in the network or for more information. We hope that you will join us in this unique effort to meet the needs of our community.

CMS Office ManageRx

A newsletter to provide medical office staff with information on health insurance.

Highlights of the November/December, 2000 issue

The CMS Office Manager newsletter is a bimonthly publication dedicated to providing your office staff with information which will help them deal more effectively with third party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on CMS analysis of the problems facing the physicians' offices.

Hassle Factor Project 2nd Annual Report continued a look at what is being done to address these issues: 1. Delay in payment, 2. Coding/Downcoding, 3. Prior Authorization/Referral, 4. Appeals.

Medicare patients' choices for 2001 Again this year, some of the Medicare HMO choices for Colorado beneficiaries are being eliminated. This is due to the withdraw of PacifiCare's Secure Horizon product from specific counties, and the complete withdraw of Antero from the market. The counties affected by the PacifiCare changes are Boulder, Weld, Fremont, Huerfano, Crowley and Otero. Antero's withdraw affects Denver, Adams, Jefferson, Arapahoe and Douglas counties. Kaiser Permanente, HMO Colorado and Rocky Mountain HMO will continue in their current service areas. PacifiCare [Antero] was required to send the beneficiaries who are going to be affected by the changes a detailed explanation of what options are available to them in their area, local resources for assistance, and information on Medigap insurance.

The Health Care Financing Administration (HCFA) began mailing the *Medicare & You 2001* handbook to all Medicare beneficiaries this month as a kick-off to the annual open enrollment period. HCFA is also mailing a copy of the handbook to physicians. If your Medicare patients come to you with questions, the following information may be helpful in directing them to the appropriate place for assistance:

Comparing Individual Payer Contracts - As you know, managed health care is still in a state of *flux* here in the state of Colorado, and the office staff can [and should] play a key role in helping their physicians evaluate the contracts they have signed. One way to do this is by giving the doctor feedback on payer performance and reimbursement issues that affect the "bottom line". Ginny Roath of Timely Insurance Payment Services offers some tips on what to consider when looking at *your* payers.

MIP - WIC - PSC - What does it all mean?

- MIP stands for Medicare Integrity Program ...
- WIC stands for Western Integrity Center ...
- PSC stands for Program Safeguard Contractor ...

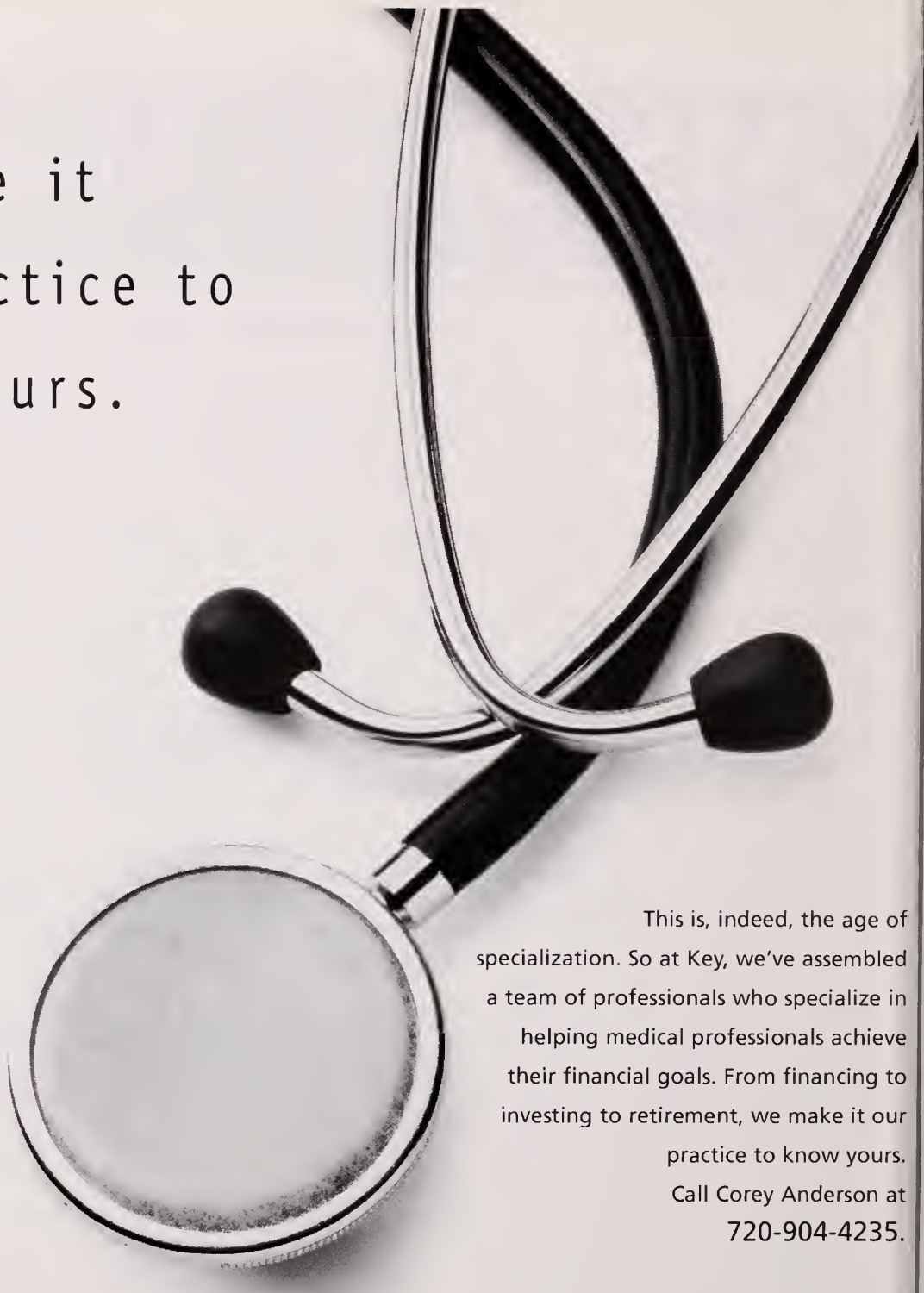
All of this means that effective 10/1/00 some of the Medicare review functions previously performed by the Part B Carrier for Colorado (Noridian) will be transitioned to a new carrier.

In response to your question...

Question: With Medicare requiring that each procedure be matched with a specific diagnosis code, I am assuming procedures will be denied if they are not. What reference will tell me what dx code will allow payment?
Answer: You are correct, if the procedure is not matched with a diagnosis code the service will be denied...

If you would like to see any article in its entirety, ask your office staff to share the latest copy of the "CMS Office Manager" with you.

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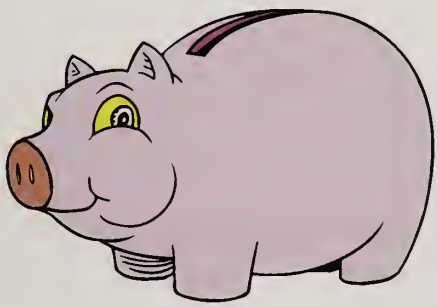


David C. Martz, MD
President, CPN

In the weeks ahead Colorado Physician Network (CPN) and Rocky Mountain HMO (RMHMO) will be moving forward with an innovative coalition in the Pueblo area. We are bringing together representatives of both "Payor" and "Provider" components of healthcare, with the intent of reversing the unacceptable escalation of costs to all involved.

Many elements contributed to this problem, including regional epidemiological illness profiles (e.g., high incidence of diabetes mellitus), as well as diverse expense components (e.g., pharmaceuticals, hospital contracts, diagnostic facilities, physician fees, etc.). Faced with resulting increased premium costs, both employers and recipients may be unable to afford coverage and choose to decline coverage in the months ahead.

The coalition will include leadership from City Council, major employers, hospital administration, broker community, network physicians, county medical society, and CPN-RMHMO. Our hope is that through data-based education and open discussion we can create consensual commitment to control rising costs without compromising either quality or access. Your continued support in these efforts will be greatly appreciated.



Save This Day

What: Legislative Day
When: Monday January 29, 2001
Where: Colorado State Capital
Who: All physicians and spouses across the state are invited.

- 8:00-9:30 Complimentary Continental Breakfast (outside Old Supreme Court Chambers)
- 9:30-11:30 Informative sessions with selected Legislators.
- 12:00 Lunch with your legislator (at the Adams Mark Hotel Downtown Denver)

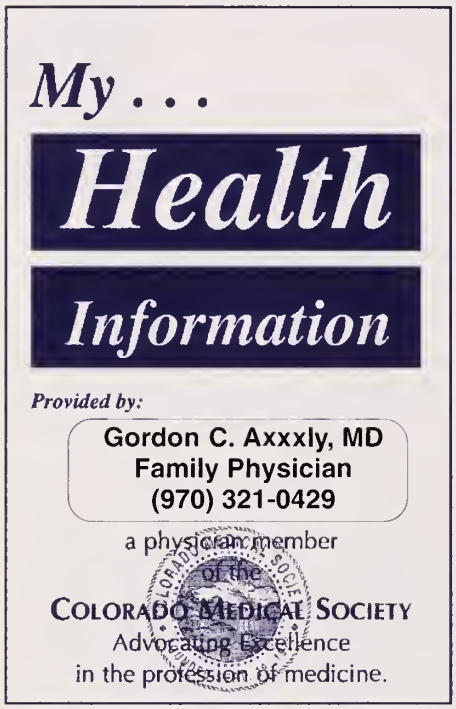
($23.00 per person)

Legislative Day is sponsored by the Colorado Medical Society Alliance in cooperation with the Colorado Medical Society. Please plan to come. This is an excellent opportunity to become acquainted with your legislators and pertinent health related legislation.

Visit the CFMC Web Page and see the many services offered to help you and your patients.

Colorado Foundation for Medical Care
at
www.cfmc.org

Are your patients fully aware of their medications?



Actual size of folded card

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of their medications. They should know what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions. That's a lot to remember, and here's a way to help them.

Every day you remind your patients to follow your directions exactly. Even so, we hear of patients taking seriously conflicting substances, such as using an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among older citizens.

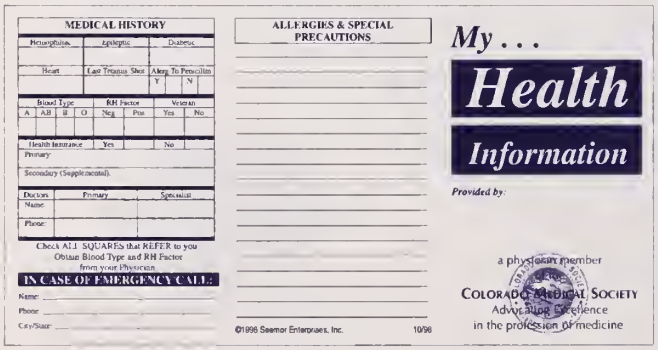
Here is a device you can give your patients which will help them remember their current medications , the dosage and the schedule. It is a handy, pocket-sized card which is constructed of sturdy plastic. . . and the card can be written on if the prescriptions change.

The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as the medical needs change. The card will hold up a long time.

These health/medication records allow you to place **your identification** on the front in a space 3/4" deep by 2" wide. CMS will even supply you press-on labels with your name, address and phone number for each of the cards you purchase. No extra cost. **Only 3 lines of copy.** We at CMS feel that your patients will appreciate you for providing them with this service, and it will be a constant reminder of the quality of care and concern you have for their healthy well-being.

These cards are inexpensive; they can be ordered in lots of

100 @ $0 .40 ea = $40.00
200 @ $0.36 ea = $72.00
300 @ $0.32 ea= $96.00.



1/2 of actual size

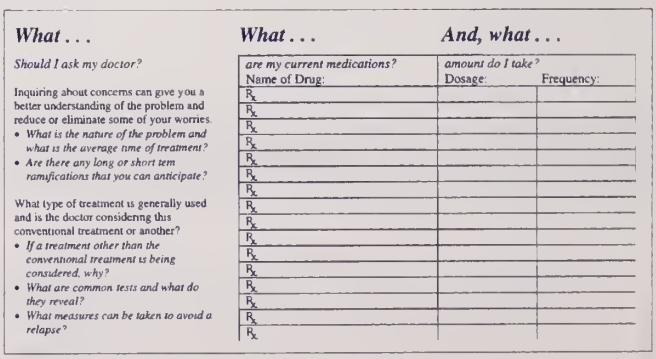
These prices include address labels and postage paid delivery. Sorry, but we cannot handle any orders less than 100.

Remember! This is a patient investment! It will serve as your representative traveling with your patient every day.

The cards are **an exclusive CMS member service.** CMS is the only place you'll find them. To order, send payment in advance to

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Denver, CO 80217-0550.

Delivery within a week of receipt of order.



1/2 of actual size

Copic Foundation Grant Recipients for 2000

The Copic Medical Foundation has awarded nearly $125,000 in grants this year. The Foundation began making grants in 1993 and since then has provided more than $1,000,000 of support to non-profit organizations focused on charitable, educational, civic, and scientific purposes related to medicine, medical research and science, and other medical charitable purposes in Colorado.

Since January 2000, grants have been awarded to the following organizations:

- Colorado Academy of Family Physicians Foundation
- Colorado Rural Outreach Program
- Colorado Springs Osteopathic Foundation
- Denver Osteopathic Foundation
- Discovery Center Museum
- Friendship Bridge
- Hall of Life at the Denver Museum of Nature and Science
- Inner City Health Center
- Kids in Need of Dentistry
- Newborn Hope
- Nine Health Services, Inc. (9Health Fair)
- Regis University
- Rocky Mountain Riding for the Disabled
- Rocky Mountain Health Foundation
- University of Colorado Aging Center

Organizations seeking funding must complete an application process detailing the purpose of the grant, the total cost and amount requested, and the organization. The Foundation prefers its grants be used as "seed" money to get programs up and running. Additionally, the Foundation prefers not to be an organization's sole source of financial support. Once an organization receives a grant, it must provide timely reports on its progress (including budget updates) and an explanation of how the project is serving the medical community.

Organizations wishing to apply for a grant from the Copic Medical Foundation should contact Ms. Pat Schultz, Assistant Vice President, Marketing Support, at (720) 858-6055 or (800) 421-1834, ext. 6055. A grant application may be downloaded from Copic's Web site at <http://www.copic.com/cmf/grant_app.htm>.

Colorado assisted in developing tobacco control programs

A new federal health report issued by the Centers for Disease Control and Prevention (CDC) provides national and selected state-level data that will assist Colorado and other states in developing and evaluating comprehensive tobacco control programs aimed at reducing tobacco use among youth and preventing the influences that might make young people susceptible to tobacco use.

"These data will serve as an important guide for evaluating teen tobacco use in Colorado," said Karen DeLeeuw, program manager of the State Tobacco Education and Prevention Partnership (STEPP) at the Colorado Department of Public Health and Environment.

The report, "Youth Tobacco Survey - United States 1998-1999," looks at all forms of tobacco use among students in grades 6 through 12, including use of cigarettes, smokeless tobacco, cigars, pipes, bidis (or beedies), and kreteks or clove cigarettes.

The report also examines knowledge and attitudes, minors' access to tobacco, media and advertising, smoking cessation, exposure to environmental tobacco smoke, and school curriculum that will assist states in designing better tobacco control programs and evaluating what is and isn't working in their efforts to reduce youth tobacco use.

Senate Bill 71, passed during the 2000 session of the Colorado Legislature, created a Tobacco Program Fund that annually allocates 15 percent of the state's tobacco settlement funds to tobacco use prevention and cessation programs throughout the state. One-third of those funds are earmarked for programs aimed at school-aged children.

Conomikes Returns to Colorado

Conomikes Associates, the practice management training specialists for nearly 30 years, is returning to Colorado with a practice workshop in December.

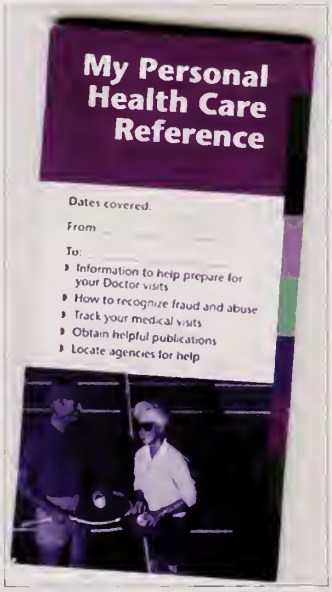
George Conomikes notified CMS that he will personally present the program, "How to Run a More Profitable Practice." The program has never been presented in the Denver area. Conomikes says "It is organized into 32 separate strategies - ranging from how to monitor your coding to determine if you are undercoding or overcoding to how to introduce a pay-plus-bonus program at your practice that will actually result in lower overall personnel costs."

The meeting is being held at the Holiday Inn Southeast (3200 South Parker Road, Aurora) Wednesday, December 6, 2000, from noon to 6:30 p.m.

To receive a program brochure, or to register for the program, call the Conomikes organization at 800-421-6512. Tuition for the program is $275.00 with discounts for multiple enrollees.

Additional copies of "Personal Health Care Reference" book available

"My Personal Health Care Reference" booklet, was recently sent out by Colorado Medical Society on behalf of the Colorado Division of Insurance. Each CMS member received a copy of the booklet, supported in part by the Administration on Aging, Department of Health and Human Services.



William J. Kirvin III, Commissioner of Insurance, stated that "the booklet was designed to provide (individuals) with tools to get the most out of your health care and health insurance. It provides helpful information about how to talk to our doctor, tracking your personal medical information, and preventing Medicare and health insuranace fraud."

Colorado Medical Society, as a member service, mailed the booklets to its members, and there are a few still on hand. If you wish to obtain additional copies, contact Tim Maloney at CMS, phone (720) 858-6313, or 800-654-5653, ext. 6313.

CMS Online

Latest news from Colorado's largest physician organization:

http://www.cms.org

CMS OnLine web page.

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Coming Soon:
The Colorado Organ & Tissue Donor Registry

The Colorado Organ & Tissue Donor Registry comes to life **November 19** with an 800 number and online enrollment. This means Colorado residents won't have to go to the driver's license office to say "yes" to organ and tissue donation. They can do it 24-7 by phone, fax or e-mail.

Donor Alliance, a non-profit organization that facilitates donation for Colorado, will have sole access to the Registry. In the spring of 2000, the Colorado Legislature authorized Donor Alliance to manage and protect the Registry. Colorado drivers who are already signed up to become an organ/tissue donor will be grandfathered in.

Hospital staff who call the OPO about potential donors will now get information about whether that person is enrolled in the Registry. If they are not registered, it doesn't mean they didn't want to donate. *A Donor Alliance coordinator should always be a part of the team approaching a family for donation.*

The Colorado Organ & Tissue Donor Registry
303-380-4802/888-256-4386
www.coloradodonorregistry.org

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

A friend in London recently gave me this bit of writing:

Why English is so hard to learn

1. We must polish the Polish furniture.
2. He could lead if he would get the lead out.
3. The farm was used to produce produce.
4. The dump was so full that it had to refuse more refuse.
5. The soldier decided to desert in the desert.
6. This was a good time to present the present.
7. A bass was painted on the head of the bass drum.
8. When shot at, the dove dove into the bushes.
9. I did not object to the object.
10. The insurance was invalid for the invalid.
11. The bandage was wound around the wound.
12. There was a row among the oarsmen about how to row.
13 They were too close to the door to close it.
14. The buck does funny things when the does are present.
15. They sent a sewer down to stitch the tear in the sewer line.
16. To help with planting, the farmer taught his sow to sow.
17. The wind was too strong to wind the sail.
18. After a number of injections my jaw got number.
19. Upon seeing the tear in my clothes I shed a tear.
20. I had to subject the subject to a series of tests.
21. How can I intimate this to my most intimate friend?

I cannot criticize the language without, at the same time, defending it against those supposedly educated people, born in the USA, born of this language who have made up their own words and definitions.

A most common exclamation these days is "I'm going to **try and do** the job." (You are going to "try **to** do" a job; the connective word, "and" should not be used because you are not joining sentence elements of the same grammatical rank or function.) Either you **try** to do the job, or you **do** the job; you can't logically "try" and "do" both in the same breath.

Another usage of the same ilk is "I **have got** a cold." If you "have" a cold, obviously you "got" the cold. (*"Have: to have in one's possession." "Got: past-tense of get; to come into possession of."*) Therefore, if both terms were to be used in the same sentence, the sentence would more correctly be: "I got have a cold." Obviously, that would not be good usage.

"Warmer temperatures" and "colder temperatures" are such common expressions by the supposed weather experts, we've nearly forgotten the true definition of "temperature". (*"Temperature: a degree of hotness or coldness measured on a definite scale."*) It's sort of like saying "We're going to have a warmer yardstick today."

A measurement can be neither warm nor cold, hot nor freezing. A measuring device, such as a thermometer, can be hot or cold, but a hot or cold thermometer has no affect on the atmosphere. Can you imagine denegrating your scientific skills by telling a patient he/she has an "unusually warm temperature"? Yet we daily hear the so-called scientific "meteorologists" on the electronic airways referring to "warmer temperatures." We also see it in print. Some even caution us about "very warm temperatures." Such misusage makes one wonder about the user's skills as a meteorologist; this could give the listener a "warm chill."

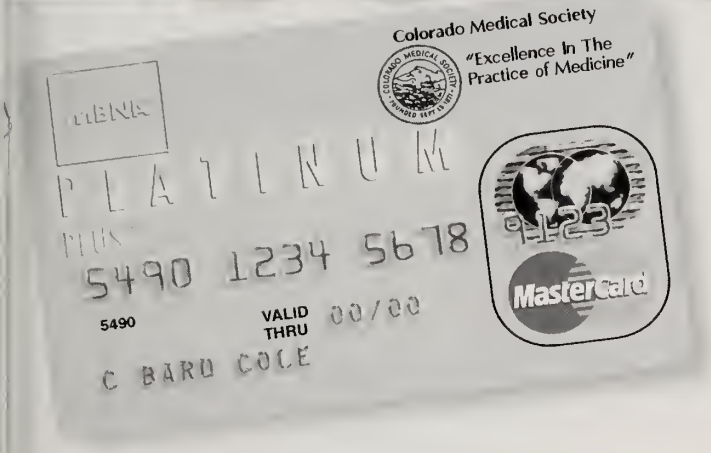
While I'm on a subject relating to the local electronic "news" media, I have another criticism. A great majority of the "reporters" speaking to the microphone begin every sentence with the word, **"Now..."** This word in their sentence structure has no bearing on anything! Why? Why should we allow the language to be so butchered? This misuse is so common that we've forgotten the base meaning of the word "now". I believe I'd rather the offender would do as so many have done for so many years: start each oral expression with the nasal gap-filler, "Uhhhh..."

How about the person referring to a "**hot** water heater." Does that replace the "**cold** water heater".

Small, maybe insignificant language parameters? Possibly, but correctness does have its place in communications. One thing I know: listening for proper word usage does tend to make a person a better listener. We can all stand some improvement in listening.

Speaking of language, one time in Paris I remarked to my wife how intelligent the children must be. I marveled that already at age 4 and 5 they were so fluent in French.

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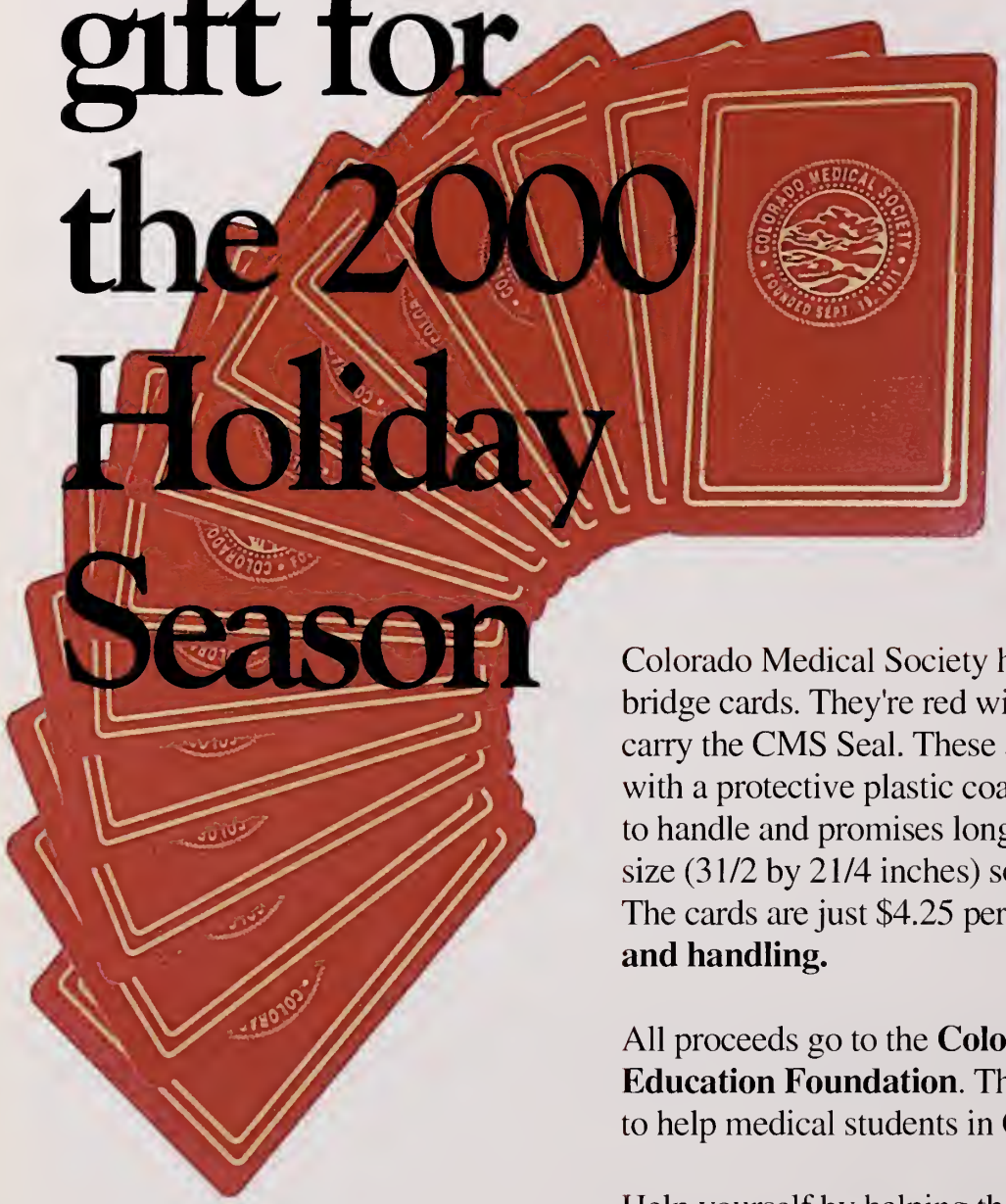
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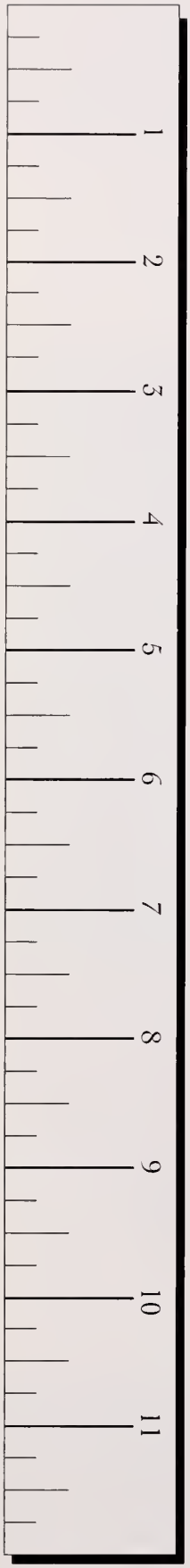
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Advances in Medical Informatics

What's new in Informatics?

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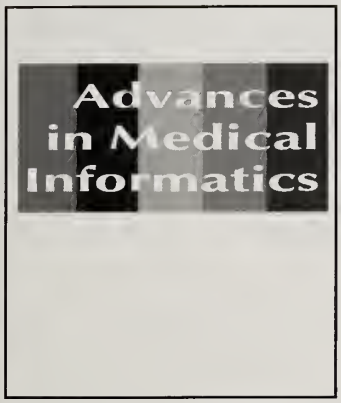
* Certification for these elements is considered current and in good standing until August 20, 2001 for managed care organization (MCO) and managed behavioral health organization (MBHO) practitioners. The National Committee for Quality Assurance is an independent, non-profit organization that certifies credentials verification organizations and accredits managed care organizations.

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COLORADO MEDICINE (ISSN-0199-7343) is published monthly as the official journal of the Colorado Medical Society, 7351 Lowry Boulevard, Denver, CO 80230-6902. Telephone (720) 859-1001 Outside Denver area, call 1-800-654-5653. Periodicals postage paid at Denver, Colorado, and at additional mailing offices. POSTMASTER, send address changes to COLORADO MEDICINE, P. O. Box 17550, Denver, CO 80217-0550. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizational and other news items regarding the editorial content to the editorial and business office. Subscriptions are available for $35 per year, paid in advance.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor. Bradley W. Pierson, Communications Assistant
http://www.cms.org/ColoradoMedicine.html

President's Letter



Richard Allen, MD
President 2000-2001
Colorado Medical Society

Last month I wrote that by the time you received ***Colorado Medicine*** the elections would be over and we would know the winners. Well, that was almost right. We know the Colorado results, but as I write this, the President of the United States is still unknown! We do know that for the first time in forty years, Colorado will have a Democratic majority in the Senate, albeit by a slim 18 to 17 margin. We've just learned who will chairing the HEWI committees in the House but not the Senate. I have completed appointments to our Council on Legislation, and they will be meeting initially on December 13th.

For those of you who are not AMA members, a recent (10/25/00) issue of *JAMA, Journal of the AMA,* has a number of interesting and relevant articles on the medical problems of caring for the uninsured. What I found most interesting was an editorial from a family doctor in California (pg 2114-6) entitled "Insuring the Uninsured. Time to End the Aura of Invisibility." In it he relates his first experience as an intern (pg 1) of being called to the ER to see a patient with a treatable condition, but who refuses care because of no health insurance and inability to afford a prescription. The author relates that "nothing in my medical education had prepared me to treat the terrible American disease of deficiency of health insurance." The rest of the editorial then continues to put forth a case for universal coverage. CMS, through our Foundation, has been actively working with the Colorado Coalition for the Medically Underserved (CCMU) to try to help solve this problem for Colorado. Since we evidently lack the national political will to accomplish this as a nation, various states have tried a variety of solutions at the more local level to address the problem. The CCMU has been conducting a number of "town hall" meetings around the state in order to gather information and disseminate ideas for solution, and the response has been good. CMS will be looking for ways to work with the State of Colorado and hopefully craft a local solution for ourselves. I have asked that our Health Affairs Council look at this as a top priority.

On a similar, but unrelated, matter I was asked to participate in a meeting on medical technology at the AMA in Chicago. A group chaired by Senator Durenberger and representing business, industry, consumer groups and policy makers wished input from the AMA on medical technology and its impact on the rising cost of health care. Some of the technological advances were remarkable. For example, a neurosurgeon has developed a brain stimulator which can completely block the abnormal stimulation in Parkinsonism, and restore total functionality in these people. An orthopedic surgeon described a bone "morphogenic injection" which would heal fractures so easily it would essentially enable adults to be like a pediatric responder in regards to healing. Think of the impact this could have for the Denver Broncos. The down side of all this is that clinical research and development costs money and that contributes to the rising cost of health care. The AMA has long had a policy of supporting an "all payers" system to support medical education and research. Currently, third party payers contribute nothing to education and clinical research, and yet they are the ones demanding evidence based medicine for efficacy or they won't reimburse for it. Clearly a political/legislative solution is needed, but how realistic is our expectation of one? Public policymakers only seem to ask, "what does it cost?", without considering what the benefits might be. I'm certain this debate will go on for some time.

Next month I will report to you on the happenings at the interim House of Delegates of the AMA. There is certain to be some items of interest for everyone, and you previously have heard how active our Colorado delegation has been at the AMA House. A number of resolutions from our House of Delegates in September were directed at instructions to our Colorado delegation to bring forward to the AMA, and this will be done.

Also, on a brighter topic, you should be getting an announcement letter from me about a People-to-People trip next summer (June 29-July 10) to Budapest, Prague, and Vienna. This should be a wonderful trip and a fascinating opportunity and experience for all of you who wish to participate. More on that later as well.

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CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Med Fax: Medico-Legal News

Robert Spencer, Esq., a shareholder with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

More on HIPAA's New Privacy Standards

By *Robert Spencer*
Shareholder
Montgomery Little & McGrew, P.C.

In an article appearing in this space in the August 2000 issue of Colorado Medicine, Patrick O'Rourke introduced readers to the HIPAA Privacy Standards.[1] The Privacy Standards are part of HIPAA's "Administrative Simplification" provisions designed to regulate, standardize and promote the use of electronic media for processing health information. Although the Privacy Standards presently exist only in draft form, they are expected to be finalized soon. The following is a preview of two new forms which physicians may ultimately wish to incorporate into their practices.

Patient Authorization Form

The proposed Privacy Standards require a written patient authorization prior to release of health information for most purposes other than treatment, billing or internal health care operations such as quality assurance, peer review, audits and the like. The written consent must contain specific elements, including the patient's name, the name of the releasing entity, the person or entity to whom the information is being disclosed, a specific description of the information being disclosed (for example, "lab results from 7/98"), an expiration date, a date and signature, an acknowledgment of the right to revoke the authorization, and an acknowledgment that release to a non-covered entity may forfeit the privacy protection. In addition, if the request for release is being made by the provider (for example, for publication in a journal) the consent form must include the purpose of the disclosure, whether financial gain may result to the requester, a statement that consent can be refused, and a statement that the patient has a right to inspect the information being used or disclosed. NOTE: An authorization which does not have all the required elements is void, and subjects the releasor to liability for an unauthorized disclosure! The draft regulations include a model form, set out on the following pages.

Note that not only do the draft Privacy Standards not require patient authorization to release information for treatment or billing, they actually prohibit it, except when release of psychotherapy notes is requested.

Notice of Information Practices

Another new requirement of the proposed Privacy Standards is to provide each patient, at the time of first visit, written notice of the provider's information handling practices. The following sample

(continued on next page)

is included in the draft regulations:[3]

NOTICE OF INFORMATION PRACTICES

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $0.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

When the final Privacy Standards are published, aspects of these forms may change; therefore it would be premature to put them into use until the regulation is final. However, physicians might find it useful to study these forms and show them to their office staff so they may become better acquainted with principles of the pending Privacy Standards.[4]

[1] *Electronic Medical Records and the Health Insurance Portability and Accountability Act of 1996*, Colorado Medicine 97 (Aug. 2000).

[2] Model Authorization Form, Appendix 2 to Subpart E of 45 CFR Part 164, as published in **Federal Register** / Vol. 64, No. 212 / Wednesday, November 3, 1999 / Proposed Rules

[3] Sample Provider Notice of Information Practices, Appendix 3 to Subpart E of 45 CFR Part 164, as published in **Federal Register** / Vol. 64, No. 212 / Wednesday, November 3, 1999 / Proposed Rules

[4] To see the draft Privacy Standards, or for more information on the other Administrative Simplification regulations, contact the DHHS website at http://aspe.os.dhhs.gov/admnsimp.

(continued on next page)

AUTHORIZATION FOR RELEASE OF INFORMATION[2]

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name:_____ ID Number:_____

Persons/organizations providing the information:

_____
_____
_____
_____

Persons/organizations receiving the information:

_____
_____
_____
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Specific description of information (including date(s)):_____
_____
_____
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Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must completed the following:
   a. What is the purpose of the use or disclosure?:_____
   _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form Initials:_____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on _____/_____/_____ (DD/MM/YY) Initials:_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials:_____

_____ _____
Signature of patient or patient's representative Date
(Form MUST be completed before signing.)
Printed name of patient's representative:_____
Relationship to the patient:_____

** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

You may not use this form to release information for treatment or payment
except when the information to be released is psychotherapy notes or certain research information.



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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

We started our CMS program year (September 24, 2000 - through September 14, 2001) off with a bang, but the calendar year (through December 31, 2000) may end with a thud. Legislatively, there are some rumblings and some general comments regarding upcoming medical-related bills, but nothing very enlightening at the moment.

Here are some bills we know are to be included:

• Concerning transitional Medicaid.

This bill directs the medical services board to promulgate rules to do the following:

- Require transitional Medicaid recipients to report earnings only if there has been a change in circumstances that could cause their income to exceed the income limit for that program.

- Disregard for purposes for eligibility determination up to the first 3 months of salary once a "1931 Medicaid recipient" becomes employed.

• Concerning the creation of a State income tax credit for employer contributions to medical savings accounts.

This bill replaces the State income tax deduction for an employer that contributes to employee medical savings accounts with a State income tax credit. Provides that the amount of the credit equals a specific percentage of the amount contributed by the employer to such accounts. Specifies a maximum aggregate amount that may be claimed for a credit. Provides that an unused credit may be carried forward for a specific number of years.

• Concerning savings accounts for prescription medications.

This bill clarifies that there is no State income tax deduction for an employer that contributes to employee medical savings accounts used for prescription medication. Creates a State income tax credit for prescription medical savings accounts. Provides that the amount of the credit equals a specific percentage of the amount contributed by the employer to such accounts.

The bill specifies a maximum aggregate amount that may be claimed for this credit. Provides that an unused credit may be carried forward for a specific number of years.

• Concerning a credit against State income taxes for prescription medications.

This bill creates a credit against State income taxes for prescription medications in actual amount expended up to $500 per individual or $,1000 per couple who have a Colorado adjusted income level of $20,000 or less for an individual or $40,000 for a couple and who do not have health insurance, Medicare, or Medicaid assistance for prescription medications. Allows individuals who have a Colorado adjusted income level of greater that $20,000 or $40, 000 per couple to claim credit, but requires the amount that may be claimed to be reduced by $2 for every $100 the person's income exceeds $20,000 or $40,000 respectively. Ties the tax credit to the excess revenues of the State.

". . .ready to roll. Meantime, best wishes for the holidays."

I am very pleased to say that Suzanne Hamilton will be back in the saddle for the 2001 session of the General Assembly. Suzanne, Director of the CMS Government Affairs Division, took some time off this year to have a baby. Mother and daughter are doing exceedingly well and Suzanne was present at the November Board meeting for her first report post baby. We note by the legislative leadership elections that some important posts are filled by legislators who have worked successfully with Suzanne and our contract lobbyist, Jerry Johnson, and CMS staff over the years. This means another plus in our government relations in the coming year. Personally, I am very glad to have our team back together and ready to roll. Meantime, best wishes for the holidays.

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Colorado Board Of Medical Examiners Notice

by Danise Hayes, Licensing Manager
Colorado Board of Medical Examiners

All Colorado ACTIVE and INACTIVE medical licenses will expire May 31, 2001.

Address Verification

Renewal notices will be mailed approximately April 15, 2001 to the preferred mailing address noted in our computer system. This address can be verified by calling the Automated Licensing Information system (ALIS) at (303) 894-7434 or (303) 894-7435, or on the Automated Licensing Information System On Line (ALISON) at ***www.dora.state.co.us/medical.***

If the home address is the preferred mailing address, ALISON will only indicate the city and state. Address changes must be received prior to March 1, 2001 to assure that the renewal is sent to the correct address. Address changes must be made in writing and can be mailed to: Colorado Medical Board, 1560 Broadway #1300, Denver, CO 80202, faxed to (303) 894-7692 or e-mailed to ***wilma.hadley@dora.state.co.us.***

Status of Renewal Application

Physicians will also be able to check the status of his or her license renewal via ALIS and ALISON. If the expiration provided by ALIS or ALISON is 2003, this indicates the renewal has been received and is being processed. Please allow three weeks from the date the renewal is sent before checking the status via ALIS or ALISON.

Maintain Records

Keep a copy of all forms you send to us. We make every effort to process all renewals expeditiously, however, there are bound to be some "misdirected" checks, questionnaires and renewal applications. Therefore, if we must request a second copy of documents from you, it will make it much easier if you have a copy on file.

Requirements

Please be advised that a correctly completed, mandatory renewal questionnaire must be received by the Board staff before your renewal will be considered complete and a new license sent to you.

Lost Renewal Forms

If you lose your renewal form, you may request a duplicate via e-mail to ***danise.haves@dora.state.co.us*** or by fax at (303) 894-7692. Renewal applications are automated with a scan code, which identifies the specific licensee. Failure to return an original renewal form will greatly delay the processing of your renewal.

If you lose the mandatory questionnaire, a copy of the questionnaire can be printed from the Medical Board's website at ***www.dora.state.co.us/medical.***

The renewal process for a physician will not be considered complete until the Board has received and accepted the correct payment, a completed renewal form and the mandatory renewal questionnaire.

License Status Change

You may use the renewal application to change your license status from ACTIVE to INACTIVE. Simply follow directions on the renewal application.

Medical License Renewal

You may **NOT** use the renewal application to change from INACTIVE to ACTIVE. This status change may only be accomplished by completing a reactivation application. You may obtain this application packet by contacting our office at (303) 894-7690, visiting our website at ***www.dora.state.co.us/medical*** or e-mail ***wilma.hadley@dora.state.co.us.***

If you attempt to change your status to ACTIVE from INACTIVE during renewals, your renewal form will be rejected.

Costs

The fee is $305 for ACTIVE status and $150 for INACTIVE status. We cannot accept credit card payments. To facilitate your renewal process the Board recommends you submit one person, per check, per renewal application. Submitting a single check for multiple renewal applications may delay the processing of the renewals.

Influenza Surveillance Conducted by the State Health Department

Kenneth Gershman, MD,MPH, Barbara Stone, MSPH, Richard Hoffman, MD, MPH;
Colorado Department of Public Health and Environment

The Colorado Department of Public Health and Environment (CDPHE) conducts surveillance for influenza each year from October through mid-May. The 2000-2001 flu season marks the third year of enhanced influenza surveillance activities at CDPHE. These activities include: collecting reports of positive laboratory tests for influenza; sentinel school reporting of absenteeism; sentinel physician reporting of influenza-like illness (ILI); and sentinel physician submission of specimens for influenza virus isolation, typing, and sub-typing. The goals of influenza surveillance in Colorado are: 1) to monitor the time course of the yearly influenza epidemic; 2) to monitor the geographic spread of influenza; 3) to monitor the circulating strain(s) of influenza virus through typing and sub-typing; 4) to assess the magnitude of the yearly influenza epidemic; and 5) to participate in national influenza surveillance activities coordinated by the Centers for Disease Control and Prevention (CDC).

Positive tests for influenza are required to be reported to CDPHE as part of the list of conditions reportable by clinical laboratories (hospitals and commercial labs) for the purposes of communicable disease surveillance and control. Influenza is not reportable by providers in Colorado. As rapid testing for influenza has become more widespread, the number of positive tests reported has also increased substantially. During the 1999-2000 flu season, 1210 positive tests were reported to CDPHE. This number represents only a fraction of influenza cases that occurred statewide since most persons with influenza either didn't seek medical care, sought care and were not tested, or sought care and were tested in the provider's office (which is very unlikely to be reported). Although the number of reported positive tests is not useful for assessing the magnitude of the yearly influenza epidemic in Colorado, these reports are useful for charting both the time course (beginning, peak, end) of the epidemic (Figure 1) and the geographic location of persons testing positive. In addition, since some of these reports are from hospitals that perform viral culture, information about the virus type is available (i.e. type A vs. type B).

School reporting of absenteeism is conducted among a sentinel network of 21 schools (19 elementary and 2 middle schools) statewide. Schools report weekly on the number of students who were absent for any reason on the most recent Tuesday. Using the school's enrollment as the denominator, weekly absenteeism for each school is expressed as a percent. The data are aggregated to express an overall absenteeism "rate" for all 21 schools which is displayed graphically by week. School absenteeism rates may be useful, when compared to data from past years, as a crude measure of the magnitude of the current season's influenza epidemic. These data may also be useful for charting the time course of the epidemic, although absenteeism data did not correspond well to positive test reports and influenza-like illness reporting during the 1999-2000 flu season (Figure 1). School absenteeism due to illness may be from a variety of respiratory, gastrointestinal, and other etiologies, however, during any given flu season, it is expected that influenza illness should result in absenteeism rates over and above the background rate due to other illnesses.

Sentinel physician reporting of influenza-like illness (ILI) is conducted among a network of 22 physicians (12 during the 1999-2000 season) statewide. Sentinel physicians report weekly on the total number of patient visits for the week, and of these, the number with ILI (based on CDC's definition of fever $\geq$100°F and cough and/or sore throat [in absence of a known cause]). These data are reported both to CDPHE and to CDC as part of the national sentinel physician surveillance network. ILI data are aggregated and expressed as a percent (percent of office visits that are for ILI) which is displayed graphically by week. ILI may be due to a variety of viral and bacterial respiratory pathogens, however, during any

(Continued)

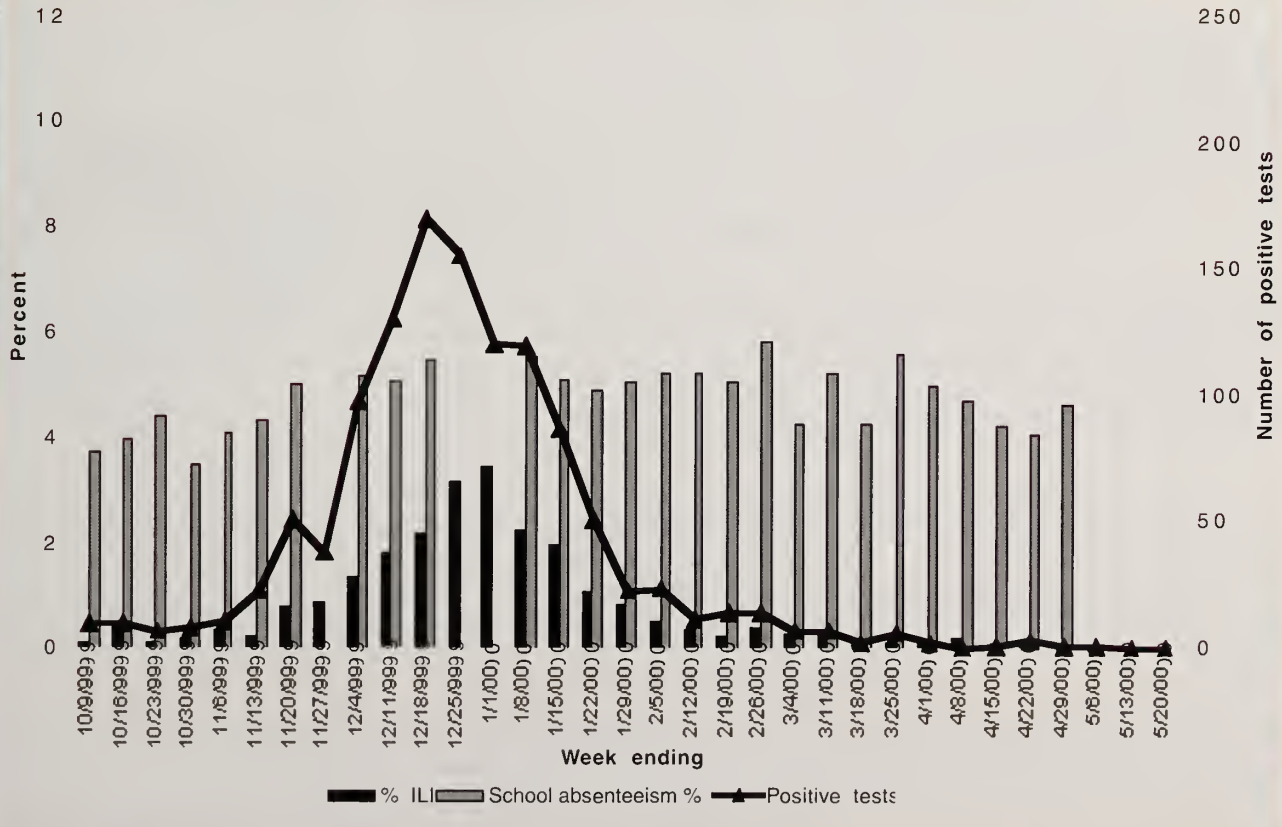
Influenza *(Continued)*

given influenza season it is expected that the increase in ILI above background will be predominantly due to influenza. These data are useful for charting the time course of the epidemic and possibly as an indicator of the epidemic's severity (as compared to previous years). During the past two seasons, ILI data have correlated closely with lab reports in terms of the time course of the epidemic (Figure 1).

Influenza virus type and subtype surveillance is conducted among the same network of sentinel physicians described above for ILI reporting. These physicians collect throat and nasal swab specimens from a sample of patients they clinically suspect of having influenza and submit these to the CDPHE laboratory for viral culture, typing, and sub-typing (i.e. H1N1 vs. H3N2). The 2000-2001 season is the first time the CDPHE public health laboratory will have in-house capacity to perform viral culture and typing; in previous years, specimens have been submitted to a contract laboratory provided by CDC. This in-house capacity will also be available to aid in the investigation of unusual outbreaks of respiratory illness at other times during the year. Specimens submitted to CDPHE that are not typeable will be forwarded to CDC for further testing; this will aid in the identification of any new strains that may appear in the US. In addition, CDPHE will forward a sample of isolates from the beginning , middle, and end of the influenza season to CDC for analyses of how well the current year's vaccine is matched to circulating strain(s) and to help determine the formulation of next season's vaccine.

Influenza surveillance data are updated weekly during the flu season on the CDPHE web page at: *www.cdphe.state.co.us/dc/dcnew.html* . Guidelines for preventing and controlling influenza outbreaks in long-term care facilities can be found at: *www.cdphe.state.co.us/hf/protocols.htm* . For further information contact Barb Stone (303-692-2656) or Dr. Ken Gershman (303-692-2657).

Figure 1: Summary of Influenza Surveillance Data Colorado, October 1999 - May 2000



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❑ Designate this contribution to the Colorado Rural Outreach Program.
❑ Designate this contribution to the Colorado Coalition for the Medically Underserved.
❑ Designate this contribution to the Colorado Medical Society Foundation general fund.

HIGHLIGHTS OF BOARD OF DIRECTOR'S MEETING

CMS Offices - Denver, November 17, 2000

Certificate of Service Award and Staff Award: Dr. Jack Berry presented the CMS Staff Distinguished Service Award to Ms. Suzanne Hamilton for her excellent work during his year as CMS President.

Dr. Berry then introduced Dr. James L. Karel, recipient of the Colorado Medical Society 2000 Physician Certificate of Community Service Award.

Copic: Dr. Jerry Buckley's report included a presentation and update on the Colorado Navinet Project (to assist physician's offices in connecting to the Internet). One hundred physicians from the Western Slope will be the first to be on-line, starting January 15-30, 2001. Copic conducted their annual planning meeting in October. Copic is studying how to take their insurance products to other states, such as Nebraska, Wyoming, Montana and Idaho. Dr. Buckley plans to meet with the Executive Directors of these states' medical societies in an effort to obtain their endorsement. Mr. Harold Williamson, a non-physician member of the Copic Board has recently passed away. Copic has an opening on their Board of Directors for a physician member, and Dr. Buckley requested input from Colorado Medical Society directors. Additional benefits have been added to Copic's Fraud & Abuse (Legal Defense) Coverage. They have also added coverage for proceedings threatened or instituted against physicians by the Drug Enforcement Agency (DEA). He presented an update on the amount and types of malpractice claims Copic has handled during the past year. There are still problems with the exterior of our new building, and if these problems can't be corrected, we will get a new exterior.

CMSA: Ms. Joyce Wilson stated that the Alliance would conduct *"Legislative Day"* on Monday, January 29, 2001. She invited the Board members to attend. There will be a continental breakfast at the State Capital, which will be in conjunction with the OB/GYN Society. Attendees will then meet with some of the legislators, and then will lunch at the Adams Mark Hotel.

AMA Delegation: Dr. Rich Quinn complemented Drs. Bob McCartney and Steve Thorson on their service to CMS as AMA Alternate-Delegates. The interim meeting for the AMA starts on December 3, 2000 in Orlando, Florida. The Colorado Delegation submitted two resolutions for this meeting. The AMA has enough support from the legislators to pass the "Patient Bill of Rights", and they are optimistic that this will pass after the beginning of the year. The AMA has been working with an entity called Atxion Corp. to form an entity called Health Care Pro Connect. This new company deals with the AMA Physician Data Base, and would supply information to pharmaceutical companies and medical supply companies for marketing purposes. Each individual physician will have control over what access to their information is available to Health Care Pro Connect.

Medical Executives Group: Ms. Sharon Rein stated that Ms. Sandi Maloney attended their meeting. She presented a legislative update, and they all discussed the implementation of the new task force created to study the future of organized medicine. Ms. Kathy Lindquist-Kleissler presented an update on the Medicare survey. Their survey reflects that most physicians now see Medicare Part B patients, but are not accepting new patients. This is most prevalent with Primary Care physicians. The Medical Executives will meet on December 28, 2000 to discuss exactly what to do with this information.

Colorado Medical Society Foundation: In Dr. Sawyer's absence, Ms. Anita Albrecht presented the report. The Foundation is beginning to receive distribution of two large awards. CMS members continue to support the Foundation with gifts. Drs. Allen and Sawyer have established a new "giving club", called the "President's Leadership Council". A gift of $1,000 per year is required for membership in the council. Ms. Albrecht reminded the Board to go through the CMS Foundation web site to do their holiday shopping.

The Board discussed the possibility of conducting an education program this Spring, and voted to not to do so. There will be no Interim Meeting of the House of Delegates in 2001 either.

The next board meeting will be held on January 19, 2001 at the CMS Offices.

In Honor Of

Honors and awards



Drs. Jim Karel & Jack Berry with Physician Community Service Award

At the Board of Director's meeting November 17th, "Immediate Past President", Dr. Jack Berry was called on to take care of some unfinished business

Dr. Berry was unable to present two significant awards at the Annual Meeting in September because the awardees could not attend. So, the pleasure was held over until November.

James L. (Jim) Karel, MD Retired, was on hand to receive the CMS Physician's Outstanding Community Service Award for 2000. He had a family schedule conflict in September but was able to be present in November. Dr. Karel remains active in the community affairs as well as medical matters. He is still participating on a couple of panels and his input is appreciated.

Another award which was held over from September was the CMS Staff Distinguished Service Award, which went this year to Suzanne Hamilton, Director of the Government Affairs Division and CMS's principal lobbyist.

Suzanne was on maternity leave in September and is now at home with her new daughter, Sophia Dawn.



Jack Berry & Suzanne Hamilton with Outstanding Service Award

Not only is Suzanne a very proud parent but she had an excellent report to the Board about the successes of the 2000 legislature and the November election of Colorado legislators. 82% of the candidates supported by the Colorado Medical Political Action Committee (COMPAC) were elected to office.

Suzanne also introduced Genni Pearman to the Board of Directors as the new Government Affairs Program Manager, who she said had done an excellent job in keeping the office going smoothly while she was on leave. Genni has, of course, been a staff member at CMS for four years, but moved to the Government Affairs office in August of this year.

Colorado physician named President-elect of American Medical Women's Association

Elinor T. Christiansen, MD, has been elected as President-elect of the national American Medical Women's Association (AMWA). Founded in 1915 for women physicians, the 8,000 member, multi-specialty organization met in Colorado Springs November 1-5, 2000. Dr. Christiansen is the second Colorado physician to be elected to this office. Dr. Catherine Anthony of Denver was president in 1976.

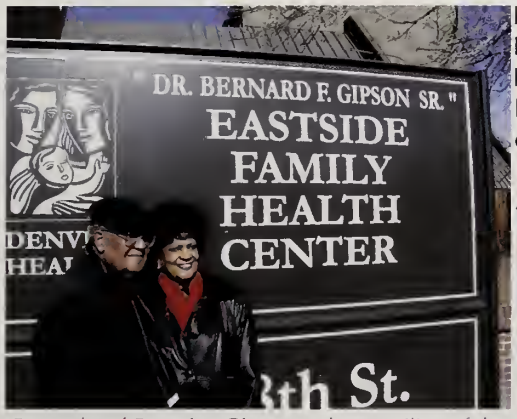


Dr. Elinor Christiansen

Dr. Christiansen has served AMWA as Vice President of Finance, as Chair of the Investment Subcommittee, and is currently chairing the Committee on Universal Access to Health Care. She also served as regional governor for the Rocky Mountain Region, and on the Awards Committee. Finances have been the main focus during her membership, which has been since 1955.

She's been working to solve the problems in access to health care, and hopes she can take a leadership role in this area. Dr. Christiansen says, "It is terribly important that physicians work diligently toward solving the problems of universal access."

She admits that her new position carries with it an "...awesome responsibility and an outstanding opportunity. I'm hoping we can start some serious debates with the new leadership in Washington. We need a fresh look at what we're doing and how we're doing it." The offices of AMWA are in Alexandria, Virginia, not far from the White House and the Capital.



Bernard and Ernestine Gipson at the unveiling of the new sign at the "Dr. Bernard F. Gipson Eastside Family Health Center", 28th and Glenarm in Denver.

For the first time in the history of Denver's neighborhood health centers, one of the centers has been named after a notable Denverite and, in this case, one of Denver's medical community notables. On November 16, 2000, Denver Mayor Wellington Webb designated the East Side Family Health Center to the "Dr. Bernard F. Gipson, Sr., Eastside Family Health Center."



Patty Gabow, MD
Director, Denver Health

There were other medical notables on hand for the renaming. Among them, Patty Gabow, MD, Director of Denver Health, Richard Wright, MD, former President of the Denver Medical Society and current Director of Community Health Services of Denver, Paula Herzmark, Chair of the Denver Health and Hospital Authority Board of Directors, Vice Chair Elbert Dean Brown, Vice Chair Bruce Rockwell, former President of the Colorado Trust, and Board members Bruce Alexander, Jr., and Dawn P. Bookhardt.

The former "East Side Family Health Center" was an important milestone in Denver medical history because it was the second such neighborhood health center in the U. S., and has been considered exceptionally successful and served as a model for many others which followed, now in the thousands.

In his remarks to a large crowd of well-wishers, Dr. Gipson said he was pleased and proud to have been able to practice in Denver for 44 years in an office just two blocks away. Dr. Gipson came to Denver first as an officer in the U. S. Air Force, and he and his wife, Ernestine, then chose Denver to settle down. One son, Dr. Bernard F. Gipson, Jr., was also attending and is an active Denver practitioner. A second son, Bruce Gipson, is with American Airlines.



Richard Wright, MD, Director
Community Health Services

The senior Dr. Gipson recalled deciding to stay in Denver after his Air Force discharge. He was the first African-American Board Certified surgeon in Colorado and retired as a clinical Associate Professor of surgery at the University of Colorado Health Sciences Center.



Mayor Wellington Webb

Dr. Gipson has received many honors in his 52 year medical career, this naming of the center for him being only the latest. He recalled how it was when he entered practice in Denver, saying "Racism was still open then; young African-Americans today don't know about that. It still exists though, but it's more insidious." Dr. Gipson said he grew up in a segregated world, but lived his professional life in an integrated society. "I've enjoyed my practice in Denver," he said, "I was a pioneer and it worked."

In introducing Dr. Gipson, Denver's Mayor Wellington Webb said Bernard Gipson was a fine member of the community in many ways, not just in medicine. Mayor Webb emphasized that Dr. Gipson's multiple roles included that of educator, inspiration, church member and community leader.

Advances in Medical Informatics

Patients To Get Web At Bedside

By Catherine Greenman

Reprinted from The New York Times, November 9, 2000.

When the new Montefiore children's hospital opens in the Bronx next fall, it will have Internet computer terminals at each of its 105 beds to help educate, entertain and heal its young patients.

The hospital, to be called the Children's Hospital at Montefiore, will be among the first to incorporate computers and limited Web access to such a degree in the care of its patients. Although no one is yet sure what tangible benefits will come out of it, the hospital's planners say they expect the computer network to be a pivotal resource for sick children and their families.

Other hospitals, like Mount Sinai Hospital in New York and the University of Chicago's Children's Hospital, have used computer-based programs from organizations like the Starlight Children's Foundation and the Starbright Foundation to allow children to connect with other children through protected networks. So far, Montefiore's pediatrics service has done little with educational or entertainment technology. But the technology program at the new hospital will be more ambitious than efforts at other hospitals, said Dr. Irwin Redlener, president of the Children's Hospital at Montefiore, and it will involve more patients and their families. Jeb Weisman, senior director of information systems and technology for the Children's Hospital at Montefiore, said he viewed the program as a learning laboratory for health professionals, who can look for new ways to enhance the quality of life for the hospital's patients.

"The first question we had to grapple with was 'What's going to be the point of this technology?'" Mr. Weisman said. "I think the jury's still out on whether you need a computer at every hospital bed." But giving patients the power to inform themselves about their illnesses, Mr. Weisman said, will help them connect their experiences to the outside world. "We have a way to engage the kids at a level that they live at every day," he said. "Technology is a part of their life, and it's going to be part of their future lives and their working lives." The hospital network will be accessible at bedsides through computer terminals. Forty-two-inch flat-panel screens will be mounted on the walls, about 11 feet in front of each bed, to show both computer displays and television. In double rooms, the screens will be angled away from each other to ensure privacy. Speakers will be situated in special hospital pillows on the beds. The content on the network will include a range of games and activities for different age groups and an e-mail program to allow children to send messages to friends and teachers and, when other hospitals offer similar services, to other patients at those hospitals. But the primary focus of the network will be educational, Mr. Weisman said. "Our first interest is in helping patients learn about the reasons they're visiting," Mr. Weisman said. "Whether they're in for asthma or diabetes, they'll be able to learn more about their condition." The hospital is also planning a computer learning center, which a patient's family can use to get information about a patient's illness. Internet content will be filtered so children and families will be able to get access to reliable medical information that they can understand, as well as to educational sites like NASA's. Data will also come from medical CD-ROMs, which will be loaded onto the network. Information will be offered in different languages.

Many factors specific to the needs of a children's hospital have been taken into consideration during the development of the network, Mr. Weisman said. The hospital planners initially considered mounting the computer screens on swing arms on the walls by the beds, for example, but they decided against that because they did not think that the swing arms would be easily movable in the event of an emergency. The network will be accessible via digital smart cards, which will allow patients to log on and pick up where they left off if they had to stop what they were doing to have a medical procedure done - or even if they had left the hospital a few weeks or months earlier and then returned. The smart cards will make remembering passwords unnecessary.

To help children who are unfamiliar with computers, the hospital plans to hire local high school students to help teach patients and their families. "There's nothing more pitiful than an adult trying to be cool in front of a kid," Mr. Weisman said, "so we're thinking older contemporaries will be more successful teachers."

Advances in Medical Informatics



John N. Withers, MD
President, La Plata Medical Society

How doctors are talking to one-another and to their patients

The La Plata Medical Society (LMS) of Durango came close to disbanding in December 1999. By December 2000 its membership had doubled and its dues had increased 3 fold to $150/year. What happened! What has brought the physicians together?

The major force for LMS during the year 2000 has been the development of a web site for the physicians and their patients. Not only has it given pride to the physicians but the community is now aware of LMS and can use its web site in the treatment of their illnesses.

The web site can be reached at ***www.laplatamedicalsociety.com.*** If you can't handle the internet then ask your grandchild for help. A local communications company put the web site together for a cost of $4000 plus $175 paid by the doctors for individual web pages. It is linked to *durango.com* and to *durango.org* (the local Chamber of Commerce web site). Presently, the LMS web site is receiving over 5,000 hits a month! Not bad for a small community.

When you pull up our home page you will see that there are 6 buttons. "Physicians" will get you all the physicians of the medical society and they can be called up either alphabetically or by specialty. Hitting on the physicians in blue will bring up their individual web pages which have their pictures, where they trained, honors, special interests, and information for reaching their offices. LMS cannot check on everything the doctors put on their pages, so at the bottom of each page we place the disclaimer, *"Information is supplied by the physician and not verified by La Plata Medical Society."*

Clicking on ***"Clinics & Groups"*** will bring up all the groups in the area and those that have web sites have them listed in blue. Hitting on one of these web sites will bring it up and the patient can find out about its physicians and the special interests of that clinic.

"Pharmacies" lists the pharmacies and their addresses and telephone numbers. No advertisements are allowed but this is a possible source of income for the society.

"Hospital" links to Mercy Medical Center, our only hospital. Their web site is a great source of information, especially through its "Library" section.

"I Have A Problem" is the pride of our web site. By clicking on this you will bring up 175 problems such as asthma, heartburn, high blood pressure, cancer, hernias, etc. Then, by clicking on a problem, the patient gets a list of the physicians in the area who treat this problem. The physicians who have a web page are listed in blue an can be immediately linked. There has been a great response in the community to this feature.

Finally, ***"Health Hints"*** is an ongoing site. First is a list of 7 recommended medical sites (there are 30,000 out there). Also we are listing articles written by our own members as to different medical problems.



Additional areas are being considered: A button labeled ***"Insurance Companies"*** is being considered as to which companies include which physicians in their plans. Charges could certainly be made to the insurance companies for this service.

Could the web site be connected directly to the offices for scheduling purposes? We will wait and see.

A society web site has been a great boost to La Plata Medical Society and should be the same for other societies. This is a start of physicians talking to each other and working together for the benefit of their patients and for their own practices.

Advances in Medical Informatics

Gallup survey finds most Americans shun using Internet for personal health informtion

"....the less confidence individuals have in its security."

Americans are unwilling to store or transmit personal health information over the Internet, according to MedicAlert Foundation, the nation's leading emergency medical information service.

MedicAlert Foundation commissioned a Gallup survey of the general public - not just Internet users - searching out the growing concerns about personal privacy in America. The survey found that the public at large is even more wary than Internet users of on-line privacy violations of personal health information.

In the national survey, 77 percent of all respondents said the privacy of their personal health information is very important, and 84 percent of all respondents said they are very concerned or somewhat concerned that personal health information might be made available to others without their consent.

As a result of privacy concerns, only 7 percent of respondents said they are very willing to store or transmit personal health information on the Internet. Only 8 percent felt a Web site could be trusted with such information. In contrast, 90 percent said they would trust their doctor to keep their personal health information private and secure, and 66 percent said they would trust a hospital to do the same. Forty-two percent said they would trust an insurance company and 35 percent would trust a managed care company.

"Improvements in Internet security technology and the development of trusted privacy policies for Web sites are essential because of the high level of public sensitivity toward disclosure of personal health information," said Tanya Glazebrook, president and chief executive officer of MedicAlert Foundation, which operates a 24-Hour Call Center staffed with trained professionals to provide emergency medical information. "Only then will the Internet reach its full potential as an accepted and practical tool in the support of health care services."

The MedicAlert 24-Hour Call Center provides physicians or paramedics with critical information regarding an individual's medical conditions, allergies, medications or implanted devices. MedicAlert also contacts family members to let them know about the medical emergency and where the patient is being treated. In addition, the nonprofit foundation recently introduced a national repository for end-of-life medical preference documents, including directives concerning life support, resuscitation, organ donation, living will and power of attorney. MedicAlert is over 40 years old.

The Gallup survey results expand upon those of a survey of Internet users commissioned by the California HealthCare Foundation and the Internet Healthcare Coalition, in which 75 percent of those seeking health-related information on-line were concerned or very concerned about Web sites sharing their personal health information with third parties without their permission.

"It appears that the further medical information gets from health professionals, the less confidence individuals have in its security," Glazebrook said. She added, "The Internet also may be perceived as impersonal. Without a real person to connect to, it's hard to trust a Web site with appropriate use of personal information."

Glazebrook noted that the foundation is developing new applications of advanced information technology to enhance its services without sacrificing personal privacy.

MedicAlert was founded in 1956 as a nonprofit organization dedicated to saving lives by providing key personal health information quickly and securely to medical professionals in emergencies. The foundation is fully integrated within the medical community, and has been endorsed by the American Association of Family Physicians; American College of Emergency Physicians; Emergency Nurses Association; American Academy of Pediatrics; American Diabetes Association; American College of Allergy, Asthma & Immunology; American Pharmaceutical Association; American Hospital Association and the International Association of Chiefs of Police.

MedicAlert Foundation can be visited its Web site at ***www.medicalert.org.***

Gallup Survey Questions and Results*

How important to you is the privacy of your personal health information?

Very important 77%
Somewhat important 7%
Not too important 3%
Not at all important 2%
Don't know 1%

How concerned are you that your personal health information might be made available to others without your consent?

Very concerned 61%
Somewhat concerned 23%
Not too concerned 11%
Not at all concerned 5%
Don't know ..... <1/2 of 1%

Would you trust or not trust your own doctor, a hospital, an insurance company, a managed care company or an Internet Web site to keep your personal health information private and secure?

Own doctor

Trust 90%
Not trust 7%
Don't know 3%

Hospital

Trust 66%
Not trust 32%
Don't know 2%

Insurance company

Trust 42%
Not trust 55%
Don't know 3%

Managed care company

Trust 35%
Not trust 55%
Don't know 10%

Web site

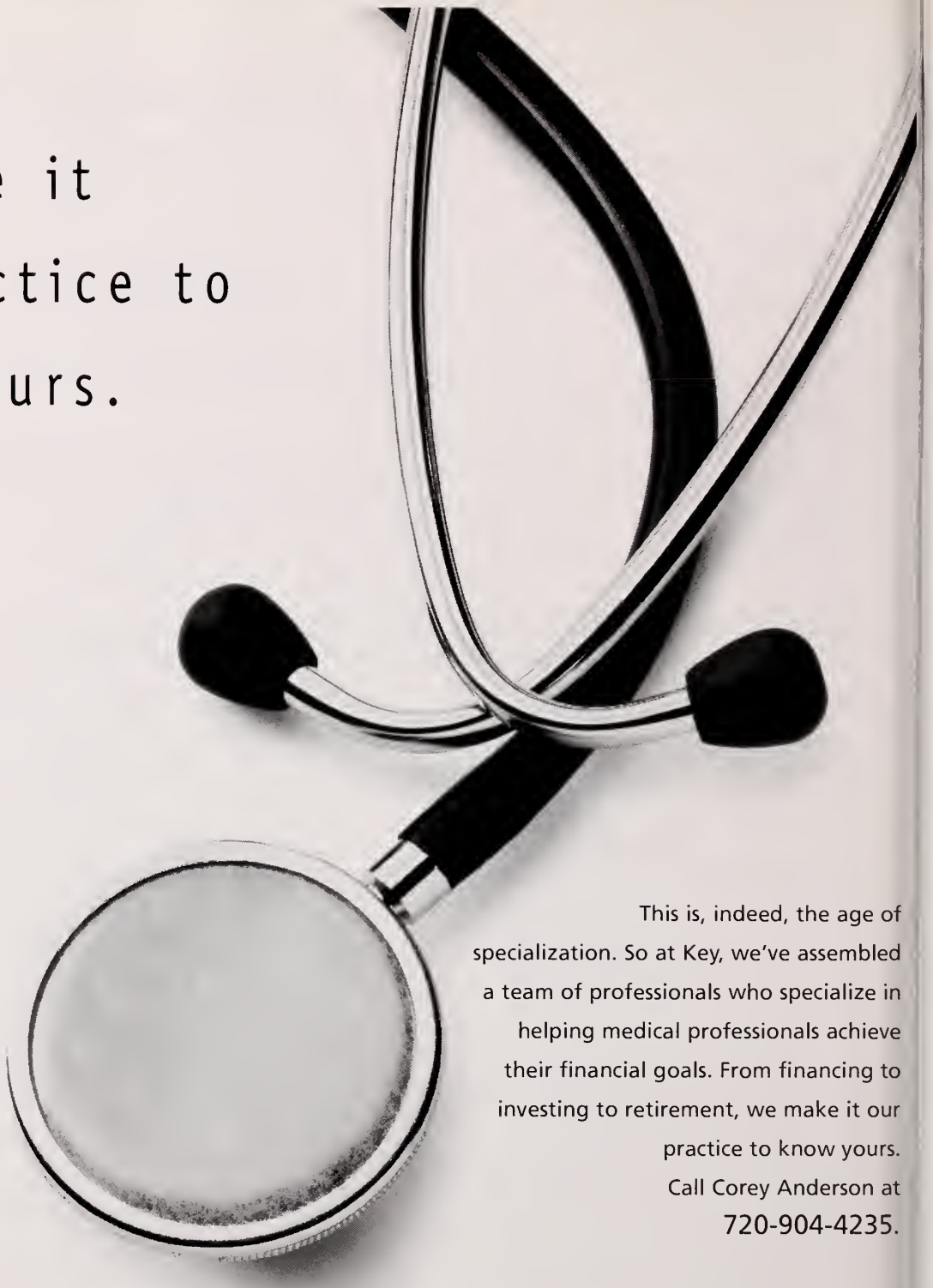
Trust 8%
Not trust 88%
Don't know 4%

How willing would you be to have personal health information stored or transmitted on the Internet if you could be confident of its privacy and security?

Very willing 7%
Somewhat willing 27%
Not too willing 20%
Not at all willing 45%
Don't know 1%

**The survey results are based on telephone interviews with a national sample of 1,000 adult men and women, age 18 and over. For results based on samples of this size, one can say with 95 percent confidence that the error attributable to sampling and other random effects could be plus or minus three percentage points.*

We make it our practice to know yours.



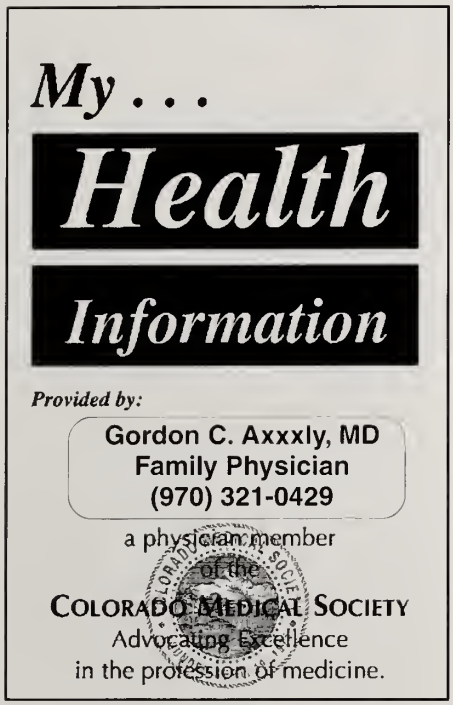
This is, indeed, the age of specialization. So at Key, we've assembled a team of professionals who specialize in helping medical professionals achieve their financial goals. From financing to investing to retirement, we make it our practice to know yours.

Call Corey Anderson at 720-904-4235.

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PrivateBank Healthcare

Are your patients fully aware of their medications?



Actual size of folded card

Colorado physicians have, for a long time, advocated that their patients, no matter what age or medical condition, should be much more aware of their medications. They should know what medications they are currently taking, what quantity or dosage, warnings to prevent unwanted reactions, conflicting substances, and their present health conditions. That's a lot to remember, and here's a way to help them.

Every day you remind your patients to follow your directions exactly. Even so, we hear of patients taking seriously conflicting substances, such as using an over-the-counter remedy while on a prescribed drug regimen. The problem is particularly prevalent among older citizens.

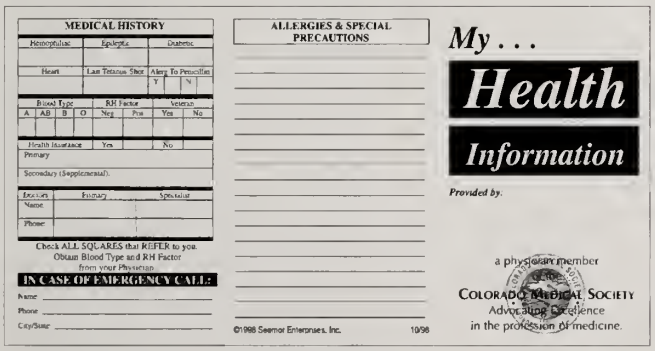
Here is a device you can give your patients which will help them remember their current medications , the dosage and the schedule. It is a handy, pocket-sized card which is constructed of sturdy plastic. . . and the card can be written on if the prescriptions change.

The card you see pictured is $6^{7/8}$ inches wide by $3^{1/2}$ inches deep, and it folds into a neat, three-panel card (actual size of folded card at right) that can be tucked into a shirt pocket or purse. It is built of a plastic that is foldable and writable. In other words, you can write on it with pencil, but can remove and change the writing as the medical needs change. The card will hold up a long time.

These health/medication records allow you to place **your identification** on the front in a space 3/4" deep by 2" wide. CMS will even supply you press-on labels with your name, address and phone number for each of the cards you purchase. No extra cost. **Only 3 lines of copy.** We at CMS feel that your patients will appreciate you for providing them with this service, and it will be a constant reminder of the quality of care and concern you have for their healthy well-being.

These cards are inexpensive; they can be ordered in lots of

100 @ $0 .40 ea = $40.00
200 @ $0.36 ea = $72.00
300 @ $0.32 ea= $96.00.



1/2 of actual size

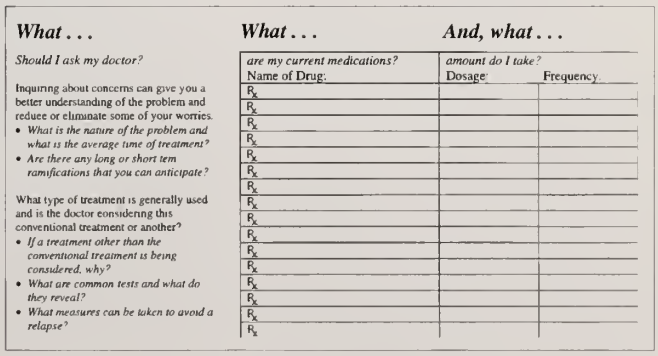
These prices include address labels and postage paid delivery. Sorry, but we cannot handle any orders less than 100.

Remember! This is a patient investment! It will serve as your representative traveling with your patient every day.

The cards are **an exclusive CMS member service.** CMS is the only place you'll find them.
To order, send payment in advance to

CMS, Member Services
P. O. Box 17550
Denver, CO 80217-0550.

Delivery within a week of receipt of order.



1/2 of actual size



Colorado Medical Society 2000 Physician Communicy Service Award

Colorado Medical Society has for many years participated with the A. H. Robins Pharmaceutical Company and the Wyeth-Ayerst Laboratories in presenting an award to a CMS member for his or her service to the community at large. This service has been in areas other than strictly medicine. For some, it has been legislative or public office; for others, it has been through individual organizations or churches devoted to community and human services.

Because these two fine companies have ceased to provide these awards, Colorado Medical Society has taken up the baton to present the

Colorado Medical Society Physician Community Service Award.

The first annual award goes to a member of the Denver Medical Society. Though retired, this physician has continued his service to his community through his church. He has become a stalwart through his hospice work and is very much appreciated in what he has done. The 2000 award has been presented to **Dr. James L. Karel.**

Dr. Karel is a past president of the Denver Medical Society. He is now a Chaplain at the Hospice of St. John's, taking his healing skills in a new and challenging direction, still the consummate listener and supporter.

Dr. Karel is a musician (piano and dulcimer), and loves music, from classical to jazz. He is a devoted gardener, specializing in chiles, eggplants and tomatoes. Dr. Karel's personal life has been devoted, first to his family and then to his medical practice. His incentive for entering medical practice was to heal, although beyond the rewards of healing the devotion and respect of his patients has continued to pay rich dividends even into his retirement years. He still calls and visits some of his longtime former patients.

James Lorin Karel, born in Pilger, Nebraska, was educated in the Nebraska public schools, at Wayne State College and the University of Nebraska Medical College. He married Janet Lee Bradshaw in 1959 and they have two daughters.

Dr. Karel has always been a strong member of the organized medicine community, and had taken part at the local and state medical societies all of his practice years. He was a member of the Judicial Council from 1978 to 1985, the Morals of Practice Committee, DMS, 1981-1982, the DMS Council on Legislation 84-87. He served on the DMS Nominating Committee, the Peer Review Task Force, Peer Review Oversight Committee , Administrative Advisory Committee, and the Grievance Comm., the CMS Council on Physician/Patient Advocacy for 3 years, and a member of the CMS House of Delegates for 10 years.

The following is excerpted from a *"Letter to the Editor"* of the Denver Post from Dr. Karel:

January, 1972

To The Denver Post:

EVERYONE IS CONCERNED about the delivery of health care in this country. Hardly a day passes without an article in a newspaper or magazine discussing the rising costs of medical care, the distribution patterns of physicians in rural and urban America, the rising premium rates for health insurance, the pros and cons of National Health Insurance, and a host of related problems.

Since the government has been increasingly involved in sponsoring health care programs, such as Medicare and Medicaid, the public is more vitally interested in the management of the Health Care Dollar, since the taxpayer must foot the bill.

Responsible physicians are acutely aware of their duty in seeing that good health care is delivered in an efficient manner. In 1950, the Colorado Society of Internal Medicine was organized and dedicated to the purpose of studying the scientific, economic, social and political aspects of medicine at the state level in order to secure and maintain the best patient care and the highest standards of internal medicine. In 1956 a nationwide American society was established.

The physician is indeed concerned with the consumers, their health problems and the way in which health care is delivered. The management of the health care dollar is everyone's responsibility. Colorado can be justly proud of the members of these medical organizations who devote their time to the issues of the day.

James L. Karel, M.D., President
Colorado Society of Internal Medicine

Here's A Gift For ALL Seasons!



The **Colorado Medical Society Education Foundation** is making available a special gift for you to give to someone. The gift will continue giving for many years.

For a contribution to the **CMS Education Foundation** of $25.00 or more, you can give this money in the name of someone you wish to honor or to remember. When you do so, everybody wins, because your contribution will be tax-deductible, the person in whose name the gift is made will receive a special letter recognizing him/her on this occasion, and the students will benefit greatly by your help.

You will receive a letter acknowledging your gift, and the letter of appreciation to the person named in the gift will know it came from you. You can be helping worthwhile young people in the field of medicine when you make such a gift.

The **Colorado Medical Society Education Foundation** is dedicated to helping provide scholarships to qualified first-year medical students entering the University of Colorado School of Medicine to lessen the financial burden of their first year. Recipients of these scholarships are selected based on the applicant's stated desire to practice in an underserved area, either rural or inner city. Their financial needs, past community service and scholastic achievements are also taken into consideration.
Won't you be a part of this extremely worthwhile program? We'll do all the work. You just tell us how much you wish to give, and in whose name.

Send your check or money order to:

CMS Education Foundation
ATTN: Gifts
P.O. Box 17550
Denver, CO 80217-0550

This can truly be a season to remember. . . by you and the gift recipient.

Member Benefits

". . . practice transition planning, long-term financial and retirement planning, estate planning and asset protection . . ."

Because of the tremendous variances in the financial marketplace today, determining a plan of investment which will offer retirement security is a continuing problem. Colorado Medical Society has provided a variety of financial services to its members , most of which have been well received. However, CMS has found that the "One service fits all" concept cannot be applied to this member benefit. Because to majority of investment counselors are also agents or brokers in their own right, there was often a grey area between the participant's "learning" something about investment and "buying" something.

To facilitate the probable needs of its members, Colorado Medical Society is now offering a series of financial planning and investment seminars around the entire state. These educational seminars are to be conducted by the firm of Sharkey, Howes & Javer, Inc., a Denver-based, fee-only firm for personal financial management. The firm has been endorsed* by Colorado Medical Society to provide these educational seminars for the physicians, spouses and family members. The seminars will be both advertised in ***Colorado Medicine***, as well as by invitation of local medical societies. The first such seminar was held in Denver November 14, 2000.

Specific goals in offering these seminars are to provide practice transition planning, long-term financial and retirement planning, estate planning and asset protection, and objective life insurance evaluation. There is no emphasis on buying anything. Theirs is a "Fee-Only" service, thereby lending objectivity to their training efforts.



Eileen M. Sharkey, CFP

Ms. Eileen Sharkey, is a native of England. She graduated from London University before relocating to the United States in 1969. Ms. Sharkey currently serves on the Advisory Board for Financial courses at Metropolitan State College, Denver, and Texas Tech University in Lubbock, Texas. She was elected to the Colorado Women's Forum in 1997 and serves on their Resource Committee for Corporate Boards of Directors. She was recently elected to the Board of Directors for Women's Estate Planning Council.

Mr. Lawrence E. Howes, a principal in the firm, has been listed



L. E. Howes, MBA, CFP

in 1999 and 2000 by ***Medical Economics*** as one of the *"Best Financial Advisors for Doctors."* Mr. Howes currently serves on the State of Colorado Department of Treasury, Investment Advisory Committee, overseeing the management of the State's $4.8 Billion in investment assets. He has also served on the State of Colorado, Securities Commissioner's legislative subcommittee on Financial Planning/ Investment Advisory Regulations. He drafted the legislative application for the first Investment Advisory Law in the State of Colorado.



Joel B. Javer, CLU, CFP

A third principal in the firm is Joel B. Javer, who specializes in equity mutual fund research and creates custom investment

(Continued)

portfolios for individuals and pension plans. He currently teaches the Estate Planning course for the Metropolitan State College of Denver.

In addition to the schedule of seminars, the firm will also be available to members through the CMS website. Sharkey, Howes & Javer will be providing CMS members with articles concerning financial matters and estate planning which will be published in ***Colorado Medicine.***

Robert Faucett, Client Service Director of Sharkey, Howes & Javer, Inc., has worked with the State Medical Societies of Florida, South and North Carolina and Virginia in similar programs. He has been working with the Colorado Dental Association (CDA) in the Client Services liaison position as well.

CDA has endorsed this firm's educational program to educate dentists in the needs and benefits of personal financial planning since 1993.

The firm providing this training is a Fee-Only service firm. Therefore, any CMS member requesting the services of Sharkey, Howes & Javer will be offered services on a reduced fee schedule as a member benefit of CMS. There will be no contacting CMS members unless that contact is requested following a seminar or the publication of an article by one of the principals of the firm.

Articles prepared on the subjects of personal financial planning, estate planning, etc., will be appearing in ***Colorado Medicine*** in 2001.

Sharkey, Howes & Javer, Inc., can be contacted through their web site at *www.SHWJ.com*

** Colorado Medical Society has provided this program with the CMS endorsement on a trial basis.*

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offered to help
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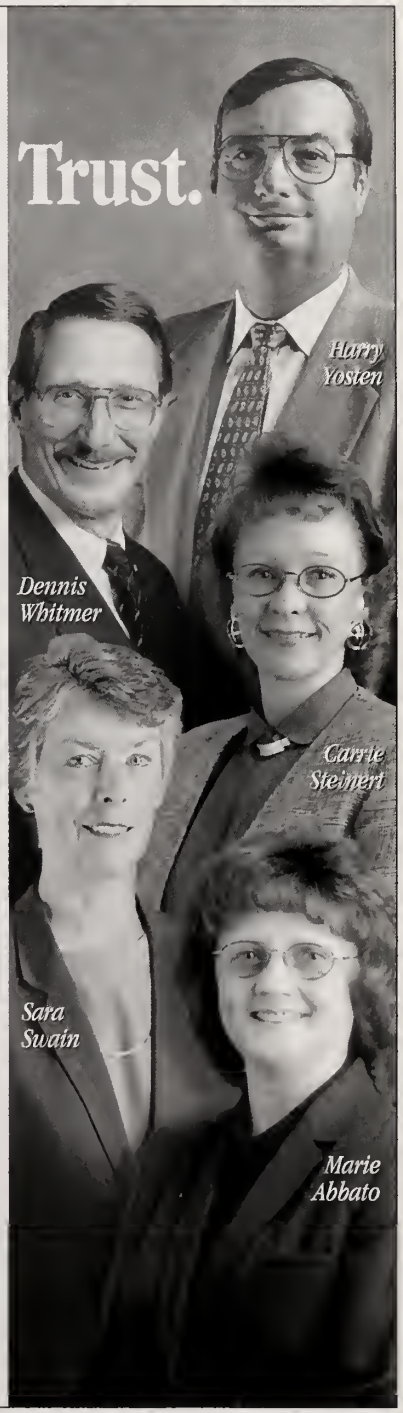
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Primary Care Conference Highlights Medication Issues

by Erich Kirshner, M.A., and Rich Kessel, Ph.D
Colorado Foundation for Medical Care.

"There can be a tendency . . . to utilize just one agent when caring for patients."

The Colorado Foundation for Medical Care and Copic Insurance recently co-sponsored a primary care conference in Denver entitled Improving Care and Reducing Errors. This CME program highlighted the crucial role played by medications in the care of patients with acute myocardial infarction (AMI), pneumonia, and diabetes.

Cardiologist Ed Havranek, MD, Associate Professor of Medicine at UCHSC, presented Management of Acute MI: Improving the Quality of Care. Dr. Havranek emphasized that aspirin, beta blockers, and ACE Inhibitors all play a crucial role in the treatment of patients with AMI. Dr. Havranek's recommendations for AMI patients included:

Aspirin: 160-325 mg immediately then daily indefinitely
Beta Blockers: IV immediately, oral within 24 hours, then indefinitely
ACE Inhibitors: oral within 24 hours, then indefinitely
Reperfusion: PTCA or thrombolytics immediately (every minute counts)

Dr. Havranek stressed the need to, "design and implement systems that maximize optimal use of therapies in all eligible patients. Remember that relative contraindications are not absolute."

Steven Mostow, MD, Director and Associate Dean for Outreach at UCHSC, discussed the role medications play in the treatment of community acquired pneumonia. Dr. Mostow emphasized the benefits of using two antibiotics when treating a ICU-hospitalized persons with community-acquired pneumonia.

Listed below are the drugs suggested in the IDSA guidelines for the initial empiric therapy of persons hospitalized with community-acquired pneumonia:

NON-ICU
- IV beta-lactam with or without macrolide
- Quinolone

ICU
- Beta-lactam plus macrolide
- Beta-lactam plus quinolone

  If Documented Beta-Lactam Allergy
  - Quinolone plus Clindamycin
  - Quinolone plus Vancomycin

Dr. Mostow urged the physicians in attendance not to wait until sputum cultures are analyzed to order initial antibiotics. He said the antibiotic order can be altered, if necessary, after culture results are available.

Philip S. Mehler, MD, Chief, Internal Medicine at Denver Health Medical Center and Professor of Medicine at UCHSC discussed Diabetes Management and Monitoring. Dr. Mehler stated that patients with diabetes should be given multiple drug agents for glycemic control as well as multiple drug agents for both lipid management and the treatment of hypertension. "These patients can often benefit from more than one medication," noted Dr. Mehler. "One medicine can only do so much." He emphasized the need to aggressively treat high blood pressure in this population since "hypertension and diabetes combined are a time bomb."

Will Schluter, MD, CFMC Director for the Health Care Quality Improvement Program, noted that Drs. Havranek, Mostow, and Mehler all focused on the need to utilize multiple pharmaceutical agents for a single clinical condition. "There can be a tendency, because of concerns about drug interactions and side effects, to utilize just one agent when caring for patients. These concerns need to be carefully balanced against the powerful benefits medications can deliver when prescribed in combination," Dr. Schluter said.

Colorado Physician Network, Inc.



David C. Martz, MD
President, CPN

On November 8th the Colorado Physician Network and Rocky Mountain HMO sponsored the first meeting of the "Pueblo Community Coalition". Pueblo has been a success story for our Rocky Mountain Physician's Choice program in terms of enrollment. In a short period of time we have grown to just under 10,000 enrollees. However, this success in growth has been mirrored by devastating financial losses-over $5 million dollars in the last two years.

After significant analysis and review we found that we are not alone. Most other HMO's have experienced losses in Pueblo over the years. Indeed, Pacificare has announced its withdrawal from Pueblo leaving over 20,000 patients and their employers scrambling for another health plan. At the same time we have had to significantly raise our premiums; often the effect of increases is that employers pass some of the cost to their employees. We expect more employees to opt out of insurance plans and increase the numbers of uninsured.

The Board of CPN and the leadership of Rocky Mountain HMO are committed to finding a solution to the Pueblo "crisis" that is less devastating than terminating our operations there.

In an effort to address this as a community problem we organized a coalition meeting of community representatives. The first meeting was attended by representatives of the physician community (including Larry Walls, MD our CPN Board representative from Pueblo), both hospitals in Pueblo, the Community Health Clinic, Southwest Healthcare, the County and City of Pueblo, Trane Corporation and a major insurance brokerage.

In addition, Commissioner William J. Kirvin, III of the Colorado Division of Insurance attended and gave his support to our initiative.

The coalition will meet in future months to create a work plan for addressing health care coverage and costs in Pueblo. Our goal will be to create a collaborative environment and break down the traditional barriers between insurance companies, physicians, hospitals, employers, community leaders, brokers and the ultimate "purchaser" -the consumer.

Once again CPN is at the forefront of protecting its member's interests and raising the "bar" for healthcare delivery.

One of CPN's objectives is to ensure that the physicians in Pueblo are not singled out and "blamed" for this crisis. The coalition agreed that education of all constituents involved was one of our greatest weapons in this endeavor.
We will keep you posted as the coalition proceeds.

Introducing. . .



Tim Maloney, Adm. Assistant
Div. of Health Care Financing
Colorado Medical Society

Tim Maloney, the newest addition to the CMS staff.

Tim joined the Division of Health Care Financing staff in September, 2000, and has been fully occupied with implementing the "Timliness of Payment" survey in October.

Tim is currently a student at the University of Colorado at Denver, majoring in computer sciences and business. He graduated from Dakota Ridge High School in Arapahoe County. One of his favorite passtimes while at Dakota Ridge was as the Drum Major in his senior year. He competed in the state finals that year. He now spends his time on skiing, rollerblading, and surfing the net.

Tim was born in Denver and is, by far, the youngest employee of CMS. If you pick up on the similarity between Tim's last name and the name of the CMS Executive Director, you're correct; Tim is Sandi Maloney's son.

Welcome, Tim. It is a pleasure working with you.

COPIC COMMENT

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company

According to James C. Collins and Jerry I. Porras, authors of Built to Last: Successful Habits of Visionary Companies, "Truly great companies understand the difference between what should never change and what should be open for change, between what is genuinely sacred and what is not." At its recent annual Strategic Planning meeting, the Board of Directors and management of Copic Companies revisited the unchanging elements of mission, core purpose, values, and vision within the context of setting goals for 2001 and beyond. What follows is the product of that meeting. It is my hope that you will see in these statements something that resonates with your own core ideology and something that you can be proud to participate in and support.

Our Mission (what we do)

* To be the premier organization providing for the professional liability insurance and other needs of the health care community.

Our Core Purpose (why we do it)

* To allow the health care community to devote the greatest possible proportion of its resources to direct patient care.

Our Strategies (how we want to do it)

* Through advocacy, innovation, and the commitment and dedication of employees who share our core values.
* Through the creation of a stable market for professional liability insurance so as to guarantee availability and affordability.
* Through the creation or acquisition of business units that support the mission and contribute to our financial strength.
* Through partnerships with other individuals and/or organizations that share our mission and purpose.
* Through the careful management of our resources and investments.

Our Core Values (what we believe to be important)

* A passion for our purpose.
* Honesty and integrity in all of our business relationships.
* Respect for the unique, impossible-to-duplicate value that the healthcare community offers.
* A sense of family internally and a sense of community externally.
* Rewards for hard work.
* A belief that patients who are genuinely injured deserve appropriate compensation delivered expeditiously.
* A commitment to resist frivolous and meritless claims
* A desire to reward and thank our customers for their loyalty to us.
* An understanding that technology can be a powerful tool to help us accomplish our mission.

Our Vision (where we want to head for the long term)

* Become the company best known, most respected, and first considered in our market area for finding ways to help the health care community devote the greatest possible proportion of its resources to direct patient care.

  When we achieve our vision, we will be perceived as the health care community's best, most trustworthy, and most valuable ally. When members of the health care community see the Copic name, they will know that they can expect better products, better prices, and better people than they could find anywhere else.

Our Goals for 2001 (what we'll focus on in the next year to move toward the vision):

* Retain and grow our core professional liability insurance business both within and outside Colorado.
* Design technology solutions to position Copic Companies for success through the year 2005.
* Position Copic Companies as a link between physician offices and the benefits of Web technology.
* Enhance net operating revenue from all operations, moving toward a goal of distributions of 20% or higher.
* Maintain the philosophical identity and focus of Copic Companies through sustained leadership and the hiring/retention of employees who understand and continue our mission.

Medicare 2001 Updates

A copy of the Medicare fee schedule for next year was mailed to all physicians at the end of November. The large packet included an expanded fact sheet from HCFA summarizing some of the changes for 2001, and a blank participation agreement. If you did not receive your copy, contact the Medicare B Carrier at the number below.

- The Medicare medical/surgical conversion factor for 2001 is being increased to $38.2581, a 4.5% increase over last year.
- If you want to change your Medicare participation status for next year, you must do so by December 31, 2000. To become participating you must submit a completed participation agreement; to discontinue your participation you must submit a termination letter; either of these would need to be sent to each Medicare B carrier where you submit claims.
- Medicare has implemented a toll free line for provider inquiries. The number for Colorado physicians is 1-877-908-8431.
- HCFA websites have updated information on local medical review policies, checkout www.lmrp.net (look for the Colorado Part B Carrier, Noridian). You can find education modules at www.hcfa.gov/medlearn. The OIG has information on the compliance guidance for individual physicians and small group practices on their website. Go to www.hhs.gov/oig (go to the reading room and then to compliance guidances). Also checkout the website for Colorado's Part B Carrier at www.noridian.com/medweb.
- HCFA continues to work on the E&M guidelines. They have hired a new contractor, Aspen Systems, to assist in the development of specialty-specific vignettes. This contractor has worked with the AMA in the past to develop some of the early vignettes. HCFA and Aspen Systems will be working with the national specialty societies in the development and review. The new term will be *examples* and they hope the examples will replace the counting of elements required under the current E&M guidelines. *Watch for information from your specialty societies and give them your input.*

If you have any questions on the Medicare updates, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (720) 859-1001 or 1-800-654-5653, ext. 6328.

Legislative Leadership Elected

Although the following is not absolute "Medical News", it is certainly "closely related news."

The Senate Democrats announced tthe Committees and their Chairs and Vice Chairs just before Thanksgiving. Committee members should be announced in the next couple of weeks.

Business Labor and Finance
Joan Fitz-Gerald Chair
Stephanie Takis, Vice-Chair

Judiciary
Ken Gordon, Chair
Doug Linkhart, Vice-Chair

Health, Environment, Children, and Families
Rob Hernandez, Chair
Bob Hagedorn, Vice-Chair

Government, Veterans & Military Affairs, & Transportation
Alice Nichol, Chair
Ron Tupa, Vice-Chair

Education
Stan Matsunaka, Chair
Pat Pascoe, Vice-Chair

Agriculture and Natural Resources
Jim Dyer, Chair
Deanna Hanna, Vice-Chair

Appropriations
Peggy Reeves, Chair
Penfield Tate, Vice-Chair

Public Policy and Planning
Pat Pascoe, Chair
Ed Permutter, Vice-Chair

The Democrats announced that Matsunaka was selected as Chair of Education to demonstrate that it is their highest priority. Thiebaut said the Public Policy and Planning Committee is intended to serve as a Committee that will look at legislation from a macro perspective and its implications on the entire system. Thiebaut used taxes and land use-growth as examples.

Hassle Factor Project 2nd Annual Report

by Marilyn Rissmiller, Program Manager
Division of Health Care Financing
Colorado Medical Society

In October 1997 the CMS Managed Care Task Force recommended to the Board of Directors that CMS implement a program similar to the Texas Hassle Factor Log analysis. The goal of this project would be to gather specific information regarding the wide variety of problems physicians' offices are having with third party payers. The complaints would be loaded into a database for the purposes of tracking, monitoring and determining the necessary actions.

The CMS project has been operational for two years. During that time we have received and logged 1540 complaints.

- During the first year members filed over 1136 complaints
- During the second year members filed an additional 404 complaints

Physicians and their staff from across the state have participated in the Hassle Factor Project - managed health care problems are not limited to the metro areas. Complaints have been received from offices located in 45 different cities in Colorado and one in Nebraska.

CMS continues to look for answers to the question:

"Why is it so difficult for the doctor to get paid for the care provided?"

To find the answers, we have used the data gathered through the Hassle Factor Project to develop a *problem list.* The top reasons for filing a complaint have remained constant over two years, however, their ranking has varied somewhat from one year to the next. *The number one complaint for both years is delay in payment.*

The Current Hassle Factor Problem List

1. Delay in payment
2. Coding/Downcoding
3. Prior Authorization/Referral
4. Appeals
5. Denial of claim
6. Incorrect reimbursement
7. Lost claims
8. Customer service/Excessive telephone hold time

So what's being done to address the issues?

1. Delay in payment

- Data from the Hassle Factor Project was used to help demonstrate the need for passage of a Colorado prompt payment law.
- Since the law took effect in January 1, 2000, the CMS staff has been helping members gain a better understanding of how the law should work for them.
- CMS continues to gather the data necessary to monitor the law's effectiveness.
- In November physicians will be sent a follow up survey to determine if there have been any changes in the timeliness of claims processing.
- If needed, the comparison results and substantiating data can be presented to regulators and/or legislators to demonstrate that additional prompt payment measures are required.

2. Coding/Downcoding

- The most prevalent coding complaint deals with bundling. Third party payers including Medicare use various software programs to reduce their expenses by denying CPT code combinations they feel are inappropriate.
- The AMA and national specialty societies are taking an active role in addressing the concerns of physicians relative to inapprppriate bundling. They have been in direct contact with the insurers and software vendors to encourage them to abide by the CPT guidelines, including recognition of appropriate modifiers. (The AMA has established a web site for member physicians to report bundling problems, it is www.ama-assn.orel ama /Driv /catep•:orv/ 2023.htm1.)
- Some national specialty societies have developed "talking points" or can provide substantiating documentation for physicians to use in their arguments with the third party payers.
- Locally CMS has begun discussions with the members of the Joint

Committee regarding physician dissatisfaction with the bundling policies that are being applied. The point that we are stressing at the local level is the need for disclosure of these policies (It is important that physicians have complete information on a plan's reimbursement policy at the time they are making a decision regarding participation.)

- CMS staff can also provide information for members or payers when a particular bundling policy is outside of the "national norm" (at this point the only policy that has been developed nationally is HCFA's).

3. Prior Authorization/Referral

- Within this complaint category there are a number of underlying contentious issues ranging from the physicians' resentment over an insurance company's desire to control costs by "second guessing" their decisions; to the need for a physician to add a staff person just to handle this bureaucratic hassle.
- The Colorado Division of Insurance (DOI) has published regulations on prior authorization, utilization review, grievance procedures and extemal utilization review. The Health Care Financing Administration has published regulations on the required Medicare beneficiary complaint procedures that are applicable under the Medicare + Choice plans. (A copy of the DOI brochures was mailed to all CMS members.)
- Through the Joint CMS/CHMOA Committee, work has been initiated on the development of a uniform prior authorization format.
- In addition at the request of one of the plans, work has begun on developing standardized wording for a patient waiver form that specialists can use when there is a question about whether the required referral has been obtained.

4. Appeals

- Complaints under this category are primarily due to significant delays in obtaining a response from the payer. CMS is currently working with members of the Joint Committee and office manager groups to develop a standardized format that can be used for filing review requests.
- In the coming months the finalized Inquiry/Review Request form and corresponding cover letters will be available for downloading on the CMS web site.
- CMS will participate on a new task force the DOI is going to set up to study the dispute mechanisms available to physicians.

As we head into the third year of the CMS Hassle Factor Project we want to continue to network with you directly and broaden the project's exposure. One of the primary motivations for continuation of the project is to improve communication and hopefully alleviate some of the frustration caused by the communication disorder that plagues the health insurance system. Please stay involved and let us know your ideas and suggestions.

The "CMS Office Manager" is a genuine Member Service

CMS publishes a bimonthly newsletter dedicated to providing the physician's office staff with information which will help them deal more effectively with third-party payers. The newsletter was developed as an extension of the CMS Hassle Factor Project, and provides feedback based on staff analysis of the problems facing the physician's offices.

The newsletter is free to the office staff of CMS members, Non members can subscribe to the newsletter at a cost of $75.00 per year.

If you are not receiving the newsletter in your office and wish to, please copy this form, complete it and fax it to Marilyn Rissmiller at (720) 859-7509, or mail it to P. O. Box 17550, Denver, CO 80217-0550.

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Practice Address _____ Practice FAX# ( ) _____

Office Manager's Name _____

Office Manager's Address (if different than practice) _____

Names of physicians in this practice group _____

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Ruminations

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor



What do you do with used election campaign signs?

I started thinking about this the other day. I drove down the street and saw literally dozens of the signs still out there on their little wire "stork-legs", stuck in the grass.

There is no practical recycling of a used election campaign sign. And there is nothing so old as the sign appealing for votes for a person or a ballot issue that has been defeated. Even today, many days after the national election, I saw signs for the presidential candidates. (Granted, there had still been no official decision on the winner.) It's sort of like Christmas decorations still hanging in full regalia two weeks or longer after Christmas has passed. I have always felt that way about the holiday lights in Denver's Civic Center staying on until after the National Western Stock Show. There's something about this garish display after the fact that does me in.

Election campaign signs are more discouraging this year than most because there seems to be no good way to get rid of any of the rather bad taste that was left after the election. The signs are also now made of some plastic material which has a half-life of about 500 years.

In the past, these signs, mounted on wooden stakes, were made of cardboard which, when caught in a rain or sprinkler, disintegrated almost immediately. There was no threat of them lasting beyond the campaign. But, now. . .

Years ago, I spent a great deal of time thinking about such oddities as used election signs, and how little use there is for one after the campaign. They're built to last, but for what? The argument reminds me of the case for the egg plant. To me, egg plants were on the same plane as Las Vegas, Nevada: there seemed to be little good reason for either one to exist; I didn't like gambling and I certainly didn't like egg plant to eat. However, Las Vegas saved itself by inventing the Hoover Dam and Hollywood stage shows. The egg plant was saved when I found that a slice of a fresh egg plant made an excellent kitchen sink stopper. After you finished with it, it could be ground up in the garbage disposal or disposed of in the trash without causing any offensive odor. But campaign signs? In addition, the longer they are around, the more offensive their odor becomes.

Since these signs are plastic (or at least plastic coated) they could be cut up to line the bird cage. Or, if you put three or four of them together, they can be used to catch the oil and greasy sludge that drops from your auto on your garage floor. They can be cleaned off and reused (for at least 500 years). **CAUTION:** Unless you are willing to see the name and office/party affiliation for whom the candidate is running, or **"VOTE NO ON . . ."** every time you drive in or out of the garage, do not try this! The verbage is not just printed on....it is baked in and virtually indestructible as well.

The wire legs can be used for your pink lawn flamingo, in case neighborhood kids get a little crazy and knock your bird off its stilt legs.

By the way, these don't burn either (the signs, not the birds). They melt, leaving an even more indestructible mass than when they were just signs.

Of course, I can't say that all of the campaign lawn signs are made of the same materials. I hope I am wrong in thinking that most of them are sturdy, long-lasting materials. They are made in the form of an envelope with the bottom side open. The sign slips over the wire frame/legs. This means that you might also be able to use a sign as a large, durable envelope, or possibly a sort of hand-held brief case with no zipper. Of course, we run into the same problem with the sign verbage: you can't get it off, so you'll always be carrying around whomever under your arm. That is, I admit, close to the old political saying, "I've got him in my pocket." In this case, you could say "I've got him/her under my arm," or "... in my armpit."

Come to think of it, that's a suitable expression for some.

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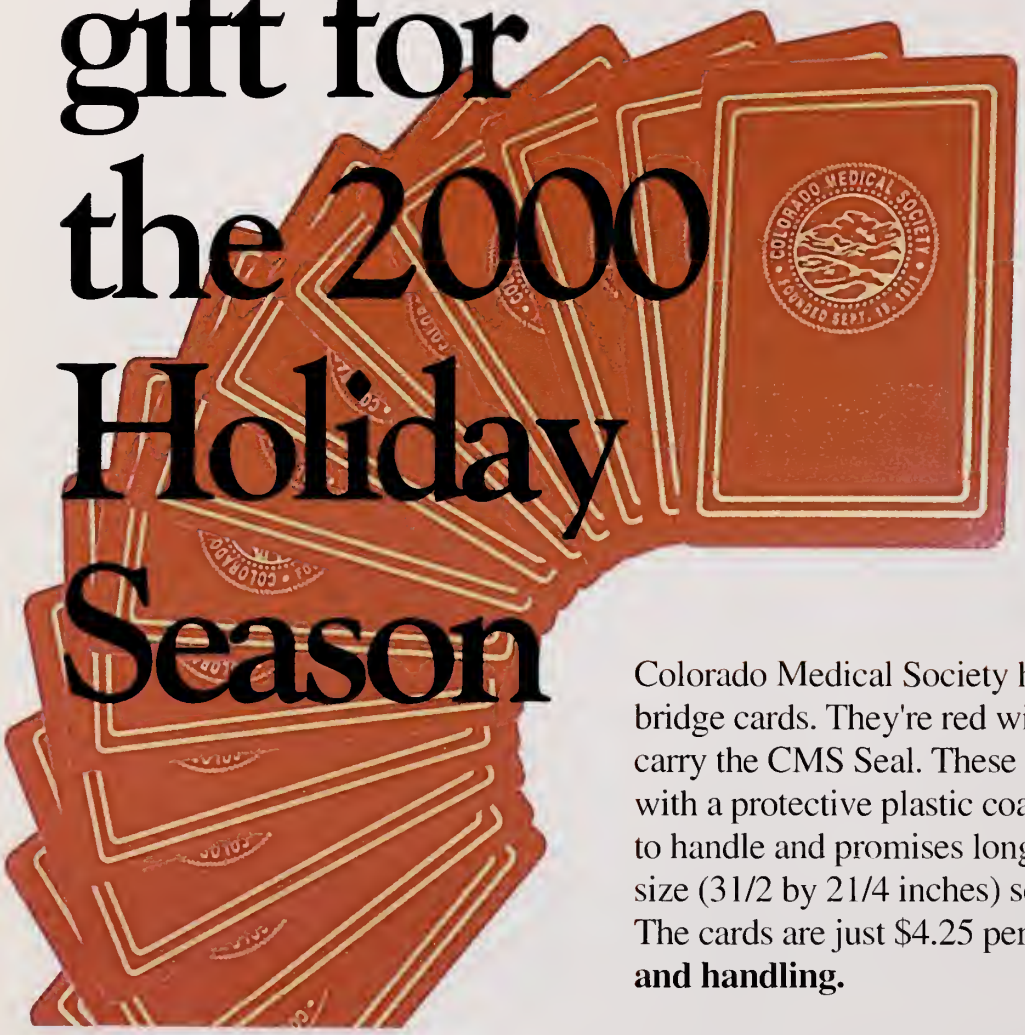
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